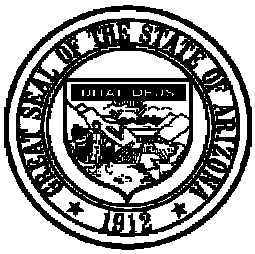

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Children, Youth, and Families

Child Welfare Privatization

A report prepared by McCullough & Associates, Inc.

December 2005

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PROJECT SUMMARY

Laws 2005, Chapter 286 (SB1513) requires the Department of Economic Security (DES) to "submit for review by the Joint Legislative Budget Committee options for the privatization of portions of the case management duties for child protective services." DES procured the services of McCullough & Associates to complete the research, facilitation, data collection, and analysis necessary to identify options for privatization of certain case management functions of the Division of Children, Youth and Families (DCYF).

The project required the consultants, Charlotte McCullough and Kathleen Penkert to: (1) provide a history of privatization efforts, including best practices in other states or jurisdictions; (2) provide an analysis of Arizona's readiness for privatization; (3) create a framework for weighing privatization options, including delineating next steps to address issues identified in the assessment phase of the project.

Organization of the Report

The document contains three sections and attachments:

Part 1 contains an overview of the history of privatization, with a synthesis of research trends and findings and commentary on challenges, successes, and recent developments. While this section of the document distills findings from various privatization studies, it is adapted primarily from a CWLA Issue Papers funded by the Center for Health Care Strategies, [1] a study conducted by Children's Rights[2], and from interviews conducted in September 2005 with private agency executives with extensive experience managing privatized case management contracts. Interviews were supplemented by primary source documents including Requests for Proposals (RFPs) and contracts. (Appendix 1 contains detailed descriptions of the case management models obtained through the interviews.)

Part 2 of this document is an assessment of Arizona's readiness to launch a successful privatized case management initiative. Findings presented are the result of focus groups and interviews conducted in October 2005 and a review of various policies, procedures, and performance reports and independent evaluations of different aspects of DES practice. Appendix 2 contains the readiness assessment survey tools used to obtain feedback from three types of Stakeholders: DCYF workers, providers, and other non-provider external stakeholders.

Part 3 of the document contains recommendations for next steps and a framework for decision makers to use as a technical resource guide to further consideration of privatization.

PART I. NATIONAL TRENDS: A SYNTHESIS OF RESEARCH

This section places privatization in an historical context; defines elements that differentiate current efforts from traditional arrangements; and, provides a synthesis of research findings on the prevalence and types of privatization initiatives, including a discussion of key design features and changes that have occurred over time.[3] Examples are inserted to illustrate different aspects of various privatized models. The section concludes with commentary on challenges, opportunities, and recent developments.

1. The Evolution of Privatization

Although there is no single definition of privatization, the term generally has come to refer to a range of strategies that involve *the provision of publicly funded services and activities by non-governmental entities*.[4]

Even before the publicly funded child welfare safety net was developed, sectarian and non-sectarian agencies created and funded various services analogous to today's child protection, congregate care, and foster care services. Since the emergence of publicly funded child welfare in the 1880s, state and local governments have paid private, voluntary agencies to provide services.[5] Historically, relationships between private and public agencies were non-competitive quasi-grant arrangements, but over the past decade, public-private agency relationships have taken very different forms.

In the current environment, contracting (also called "outsourcing") is the most common form of privatization in the areas of child welfare, behavior health and juvenile justice. Unlike the former informal, noncompetitive arrangements between public agencies and nonprofit providers, today's contracts are typically awarded after a competitive procurement process.

The services that are privatized and the manner in which payment is made also have changed. Until the past decade, public agencies typically retained case management decisions and control over the types, amount, and duration of non-case management services that were delivered by the private sector. Under this traditional child welfare per diem or fee-for-service contracting model, the private agency simply agreed to provide placement or non-placement services to a certain number of children in return for payment based on a pre-determined daily or fee-for-service rate. The contractor was paid to deliver units of service and rarely was reimbursement linked to any measures of effectiveness of the services provided. Such a payment approach offered few incentives for service providers to control costs, to build a more suitable array of services as an alternative to placement, or to more quickly return children to their families. In fact, these contracts provided incentives to continue delivering more of the same service whether it was needed or not.

In recent years, over half of the state's public agencies have moved away from these traditional arrangements to a variety of risk or performance-based contracting options, often resulting in the contractor being given case management responsibility and greater flexibility and autonomy in determining how funds are used to meet the needs of individual children and families. The new privatization models are varied, but certain features have characterized most of these efforts, including the following:

PART 1: NATIONAL TRENDS

- Public agencies have shifted case management responsibilities to private agencies;
- Public agencies are more likely to purchase results rather than services; and,
- Financing mechanisms increasingly link implicit or explicit fiscal incentives to performance.

Privatization in child welfare takes many forms, with the respective roles of the public and private sectors varying, depending on the financial arrangements and the nature of the service that is being privatized. In addition to the term privatization, these reforms have been called a variety of names: public-private partnering, managed care in child welfare, community-based care, and results- or performance-based contracting. Regardless of the term, most of these initiatives have placed an increased emphasis on outcomes, or value for money spent, with a goal of getting improved results for the same or less money.

By most accounts, the privatization of child welfare services, especially case management, appears to be on the increase. Some observers argue that the trend has brought higher quality and greater efficiency, but others have raised concerns about its appropriateness. Still others contend that the essential issue is not whether but how privatization should be accomplished. While the federal government does have a policy indicating that inherently government functions should not be contracted out[6] federal law has not addressed the nature of state public agency/private agency child welfare contracts. Instead, child welfare public-private contracting has been governed by state law and regulation.[7] The U.S. Department of Health and Human Services Children's Bureau recently awarded funding to support a Quality Improvement Center on Child Welfare Privatization with the intent of building the knowledge base about effective privatization practices, particularly in relation to adoption services, that may result in improved outcomes for children and families.

There are abundant sources of information about child welfare privatization. There have been periodic national or targeted surveys of public administrators conducted to collect both quantitative and qualitative information on the types and prevalence of changes; identify barriers and any perceived or actual successes; track trends over time and identify emerging issues; and report and disseminate findings, often including recommendations for change.[8]

Other researchers have used case studies to look in-depth at one or more initiatives. Case studies have used combinations of document review and data analysis, phone interviews, and site visits. One of the most thorough and recent efforts to advance understanding of the current use of privatization, including the extent to which privatization achieved benefits or resulted in unintended consequences, was completed by Madelyn Freundlich of Children's Rights. Freundlich accomplished this in three ways: 1) by describing the concept and purported purposes of privatization; 2) using a case study approach to look at six different jurisdictions; and, 3) synthesizing the lessons learned and offering guidance to communities considering privatization.[9]

Detailed information on individual initiatives is found in independent evaluations (including evaluations of the two most comprehensive, statewide privatized systems, Kansas[10] and the University of South Florida's evaluation of Community-Based Care in Florida).[11] According to the last CWLA management, finance, and contracting survey, over half of the 39 initiatives described in the report were planning, in the midst of, or had completed independent evaluations. One of the most comprehensive was the evaluation of Colorado's pilot capped allocation projects.[12]

2. National Trends

For nearly a decade, the Child Welfare League of America (CWLA) conducted periodic surveys of all 50 states and the District of Columbia (and a number of counties) and published findings related to the types of changes, if any, public agencies were making in how they managed, financed, or contracted for services. Survey responses were often supplemented by documents provided by the public agency respondents, including planning documents, RFPs, contracts, and evaluation studies.

The last published report in 2003 was based on responses from 45 states and the District of Columbia obtained in 2000-2001. The reports provided detailed profiles and aggregate analysis of 39 initiatives from 25 states.[13]

Broad Goals & Impetus for Change

In all of the CWLA surveys, public agency respondents described overarching goals that related to legal mandates of safety, permanency, and well-being. Many also cited goals related to increasing accountability or purchasing results. Since the introduction of the federal reviews, the Child and Family Service Reviews (CFSRs), it seems likely that as states weigh privatization options, they will introduce initiatives that respond to CFSR findings and link privatization efforts to the State's Program Improvement Plans. A range of factors has motivated privatization initiatives. Some were made possible by the Title IV-E waiver program that allowed states more flexibility in how they spent federal funds. Others were a direct result of lawsuits, settlement agreements, or an overall negative public perception of how the public child welfare agency was performing. Increasingly, initiatives appear to be driven by legislative mandates (41% of the CWLA initiatives). No state has a broader legislative mandate than Florida.

Impetus for Change

Kansas' statewide initiative was implemented as a result of a lawsuit as well as pressure from the governor and legislature to privatize services.

The performance-based contract reform in the District of Columbia is part of the federal court settlement agreement that allowed the public agency to emerge from receivership.

Most recently, in 2005, the Texas legislature passed a bill requiring the public agency to develop and gradually implement a plan for privatizing foster care, adoption, and case management services for children requiring out-of-home care (SB6).

Legislative Mandates in Florida

In 1996, the Florida Legislature mandated four pilot programs that privatized child welfare services through contracts with community-based agencies.

In 1998, HB 3217 mandated statewide privatization of all foster care and related services. Related services included family preservation, independent living, emergency shelter, residential group care, therapeutic foster care, intensive residential treatment, case management, post-placement supervision, adoption, and reunification.

Child protective service intake and investigations remain in the public sector to be managed by DCF or by the sheriff's departments.

PART 1: NATIONAL TRENDS

The Scope

Most privatization initiatives are limited to a particular region of a state or a subgroup of the child welfare population. Some initiatives are small, contained pilots that stay small. Others eventually expand. A few projects from the onset were intended to cover most or all of the statewide child welfare caseload. Florida and Kansas are the two best-known examples of the latter.

The Range of Privatized Services

Services included in the 39 initiatives described by CWLA varied depending on the target population.

The Hotline function and the initial child protective services (CPS) investigation were retained by the public child welfare agency (or in some locales by law enforcement) in all of the 39 initiatives. Beyond those initial intake and investigation functions, however, the full range of child welfare services has been the focus of different privatization initiatives.

Arizona is not the only State exploring privatization of case management services. In fact, case management services were the most likely services to be included in the initiatives reported by CWLA. Each initiative defined case management services in its RFP or contract with great variation among initiatives. In some initiatives, private agencies have assumed some or all of the core case management functions from the time of referral until the achievement of permanency.

Finding

In the last CWLA survey, the most likely service to be included in a privatization initiative was case management (or care coordination), with over half of the initiatives including the privatization of case management.

The responsibilities of the private agency might include placement and service delivery functions in addition to case management. In Florida, for example, the private community-based lead agency receives the case during the investigation when it becomes clear that ongoing services (either in-home or placement services) are needed during or post-investigation, and the lead agency retains the case until the case is closed. Case management is privatized for all children post-investigation regardless of whether the child is served in-home or out-of-home and whether services are provided under court supervision or under voluntary services. The private agencies work with families to develop and implement the case plan and set permanency goals; manage court related processes; make placement and discharge decisions; and recruit, train and support foster and adoptive families.

In many states, case management is fully or partially privatized only for a defined subset of the child welfare caseload, again with great variation. In some states, the focus of the privatized case management agency is on diverting low-risk children from the formal child welfare system during or following the investigation that is conducted by the public protective service worker (or, in some jurisdictions, by the sheriff's department). Arizona's Family Builders was an early example of an early intervention model. More recently, in 2005, Iowa launched a similar community diversion initiative for children and families in need of services (but not an open CPS

case) to be served by community-based providers. Under that model, the public agency retains case management for all other cases.

In other states, the emphasis has been on privatizing case management and services for children at the deep-end of the system, usually those who present with complex needs and require placement in therapeutic levels of care. Many of the early models tracked by CWLA were focused on that small percent of cases that consumed a disproportionate share of resources. The rationale was that if children with complex needs could be better managed and stepped down or out of the system sooner, more children could be served for the same or fewer resources. Some efforts were more successful than others in achieving this goal. The *Commonworks* initiative in Massachusetts is an example of a successful effort. For nearly a decade, a portion of the State's children in need of residential care were referred to private agencies who coordinated care and provided or purchased services from other community providers. In this dual case management model, the public agency caseworkers retained final decision-making in terms of permanency goals and other key decisions, working in tandem with private case managers. (Appendix 1 contains more detail on *Commonworks* and an interview with a lead agency executive who describes the recent dismantling of *Commonworks* as part of the launch of a new initiative, thoughts on dual case management systems, and the lessons learned).

In some initiatives, children with complex service needs who are served by multiple public agencies are the focus of the privatization effort. Cross-system funds are blended to support a coordinated case management and service delivery system. The Missouri Interdepartmental Initiative is a good example of this approach. In that model, a private agency was given total case management responsibility for a limited number of children referred in a specific region of the state. (Appendix 1 contains a description of the initiative and an interview with the lead agency executive).

Some states have privatized case management for children in need of traditional foster care or home of relative care. The performance-based contracts in Illinois and Michigan described later in this section provide examples of how States aligned payments with desired results in specific program areas.

Many states have privatized case management for children with adoption as a permanency goal -- with variation in the time the transfer of case management occurs (pre-or post termination of parental rights) and in the financing mechanism. Michigan was one of the earliest States to structure its payments to private agencies to reward timely achievement of adoptions with payments decreasing the longer the agency worked to find and place a child with an adoptive family. (See Appendix 1 for examples of privatized adoption contract provisions from Massachusetts and Kansas).

With few exceptions, initiatives that privatized case management also have included the provision or management of many other services in addition to case management. For example, an agency responsible for case management might also be responsible for providing in-home and out-of-home care placement services, recruiting and licensing foster families, and providing pre- and post adoption services.

As noted in the examples, the degree of public agency involvement and ultimate authority in case management decisions has varied from one initiative to another. In some states, the public

agency has delegated virtually all control to the private contractor (See Florida, for example, in Appendix 1). In other initiatives, the private agency has control over certain decisions but the public agency retains control and requires prior notification for significant milestones and has veto power over key decisions.

When private agencies assume responsibility for core functions, the public agency retains responsibility for oversight. The public agency must set the standards, define the outcomes and performance expectations, and then monitor performance through contract monitoring and quality assurance and improvement activities.

Structural Designs

There is no one "business model" or structural design for privatization that has been proven to be superior to another. When public agencies contract for case management and other services, they typically rely upon private, nonprofit contractors. Fewer than 10% of the initiatives described by CWLA, for example, contracted with for-profit entities.

CWLA reported the majority of initiatives are using a lead agency model (51%) supported by a provider network or other collaborative service delivery arrangement. The lead agency model is what is being used under Florida's Community-Based Care plan and the Kansas privatization model. Under this type of arrangement, the public agency contracts with one or more agencies within a designated region to provide or purchase services for the target population from the time of referral under the obligation ends -- often at case closure. Some lead agencies provide most, if not all, services with few or no subcontracts. Others may procure most

Lead Agency Responsibilities in Florida

In the last five years Florida has transitioned to a community-based child welfare system. The Department has contracted with 22 regionally defined lead agencies and each must have the capacity to:

- Develop a comprehensive array of in-home, community-based, and out-of-home care options through a provider network;
- Manage the funds and address cost overruns;
- Provide or subcontract for the direct provision of all services needed by all children referred by the PI: in-home services, foster or kinship care, adoption, Independent Living;
- Approve, review, authorize, and pay provider's claims;
- Design and implement a comprehensive, individualized case management system;
- Develop 24/7 intake and referral capacity;
- Ensure child & family involvement and satisfaction at all levels of case management and service delivery;
- Handle all court-related processes;
- Establish a quality assurance system to ensure continuous improvement;
- Meet all specified safety, permanency, and well-being outcomes and system performance indicators as required by the contracts; and,
- Gather and report all information required for quality and performance oversight.

services from other community-based agencies and directly provide case management and/or limited services. Some contracts impose a cap on the services that the lead agency can deliver if it assumes case management.

Finding

In all of its various forms the lead agency model has been the most common in child welfare privatization.

Some lead agencies are single agencies that have long histories as child welfare service providers, while others are newly formed corporations that were created by several private agencies for the sole purpose of responding to the contract opportunity. A few lead agencies were created through collaboration between nonprofit agencies and one or more for-profit organizations.

Performance-based contracts between the public agency and private providers are found in nearly a quarter of the CWLA initiatives. In this model, either payment amounts or schedules are linked in new ways to performance or achievement of certain case milestones, or the providers are given case rates for certain populations and expected to achieve specified results.

Performance-Based Contracting in Michigan

Michigan began the Foster Care Permanency Initiative as a pilot project in 1997 in Wayne County (Detroit). The goals were to reduce the length of stay in foster care and increase the numbers of children who achieved permanency within the specified time frames.

The planners created the funding structure to provide foster care providers with flexibility. The principal design is a reduced per diem rate and a reallocation of the resulting savings into three lump sum incentive payments tied to performance goals.

There are few strings attached to the lump sum payment—allowing providers to purchase or provide whatever services or supports are needed to achieve the results.

Lump sums are paid at designated milestones of each case——an initial referral payment, a performance payment, and a sustainment payment. The daily rates and the incentive amounts have changed multiple times since the project was first launched.

Illinois was among the first states to implement performance contracts for kinship and foster care providers. In FY 2000, slightly more than 21,000 children were served statewide using performance contracts. This shift was accomplished by redesigning how new children are referred to foster care agencies for placement. Performance contracting (initially implemented only in Cook County), requires all agencies to accept an agreed upon number of new referrals each month with the expectation that a certain number of children in care would exit care to permanency each month. Falling short of target percent of children exiting care means serving more children without additional funds. In Illinois, agencies must absorb the costs of any uncompensated care. If the number of children in excess of the payment level exceeds 20% of the number served, the agency risks the loss of the contract. By exceeding the benchmark in permanency expectations, an agency can reduce the number of children served without a loss in revenue. Agencies also receive $2,000 for each child moved to a permanent placement beyond the contract requirement.

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Public agencies are increasingly using performance-based contracts with both lead agencies and with single providers. In some instances the performance-based trend is a direct result of legislative action or litigation. In Iowa, for example, the *Better Results for Kids Initiative* calls for the State to move towards performance-based contracts with all service providers. Similarly, for the past three years, the District of Columbia has been transitioning to performance-based contracts for the requisition of all services as a requirement of its settlement agreement approved by the federal court.

Quality, Accountability & Performance Expectations

Finding:

There is a premium placed on data collection to support QA/QI and contract monitoring but there is also evidence that many current automated systems may not be up to the task.

Regardless of the structural model, public agencies are focused on improving quality—with all initiatives including some methods to collect and manage utilization, quality, outcomes, and fiscal data. Perhaps the most important change with privatization relates to what gets monitored. In many traditional child welfare programs, monitoring mechanisms, to the degree that they existed, focused almost exclusively on process issues, i.e., were certain tasks performed (assessments, number of visits, therapy sessions, etc.). The new initiatives are part of a broader trend that seeks to follow client outcomes in addition to or instead of process indicators.

Most initiatives specify performance standards, improved functioning indicators, and client satisfaction requirements in their Requests for Proposals (RFPs) and their contracts. Specific outcome measures vary according to the target population served by the initiative but initiatives are most likely to include indicators related to child safety, recidivism/reentry, and achievement of permanency within the timeframes required by the Adoption and Safe Families Act (ASFA).

States and counties use multiple methods to collect and manage data on their privatization initiatives. Many plans appear to rely heavily on reports generated by the contractor or from the State's automated MIS. However, both the findings of the independent evaluators and the responses to the 2001 CWLA survey indicate that data collection and management remain challenges for public and private agencies across the county.

The CWLA survey also asked whether the Statewide Automated Child Welfare Information systems (SACWISs) were used to collect and report cost, outcomes, and utilization data for the initiatives described. Twenty-eight respondents (71.8%) answered this question, and of those, only five (17.9%) stated that they were using SACWIS for the initiative. Many others indicted that they had plans to adapt their SACWIS to collect this type of information.

Respondents also were asked whether their state or county had the ability to track the overall effect of the child welfare initiative on other child-serving systems. Only four of the initiatives reported this capability. The lack of ability to track utilization, costs, and outcomes for children and their families across child-serving systems is problematic. There is also a gap between information that is tracked and information that is actually used for system planning and improvement. Child welfare initiatives appear to have difficulty generating data in a form and in a time period that is relevant and helpful for planning and decision-making.

In addition to data obtained from the MIS and standardized assessments, states and counties reportedly use a variety of approaches to monitor performance. Frequently cited methods for collecting outcome and performance information include:

- Reviewing quarterly reports,
- Reviewing case records,
- Using quality assurance protocols,
- Using monthly problem-solving meetings,
- Making scheduled and unscheduled site visits,
- Reviewing disrupted placements and critical incidents, and
- Conducting independent evaluations.

Funding Sources

The bulk of federal child welfare funding is disproportionately directed toward out-of-home care—the very part of the system that public agencies are seeking to minimize. Given the complexity of child and family needs and the inadequacy of child welfare funds to support preventive, home-and community-based care, and therapeutic services, child welfare agencies have traditionally tapped other federal, state, or local funds. Each funding source may come with different program eligibility and match requirements.

As child welfare agencies strive to rearrange fiscal relationships, payment mechanisms, and introduce risk based contracting, they have to also ensure that the proposed changes will not negatively affect their ability to access funds from sources outside child welfare or to maximize federal revenues. To accomplish these goals, some States (like Arizona) have operated under a Title IV-E waiver allowing the state to spend Title IV-E funds on a range of alternatives to foster care as long as the overall expenditures are cost-neutral to the federal government. Other States have attempted to maximize federal revenue and gain greater flexibility over limited dollars by changing the funding mix—combining child welfare, TANF, Medicaid, and

An Integrated System of Care

Wraparound Milwaukee has been in existence since 1995. Wraparound currently serves about 1000 children who have serious emotional disorders and who are identified by the child welfare or juvenile justice system as being at risk for residential placement; children with behavioral health problems who are referred by child protective services who have not yet been removed from home; and, a population of mothers (and their children) who are involved with the substance abuse, welfare-to-work and child welfare systems.

A combination of federal, state, and county funds is used to finance the system. A pooled fund is managed by Wraparound Milwaukee, housed within the Milwaukee County Mental Health Division, which acts as a public care management entity. Wraparound Milwaukee utilizes managed care technologies, including a management information system designed specifically for Wraparound Milwaukee, capitation and case rate financing, service authorization mechanisms, provider network development and utilization management, in addition to coordinated care management, provided by private agencies.

The overall reduction in expenditures from 1996 to 2000 has resulted in $8.3 million in savings for the County.

behavioral health block grant dollars in new ways to support children and families involved with the child welfare system. When multiple funding sources are used, the child welfare agency has had to reach agreement across child serving agencies on how funds will be included in the child welfare contract or made available to the child welfare contractor or public agency by some other means.

Finding

The core funding reported for the child welfare initiatives comes primarily from child welfare sources, but the vast majority of initiatives (72%) are supported by other funds, particularly Medicaid and mental health.

The 2001 CWLA survey explored the sources of funds used by child welfare agencies to support their child welfare initiatives. Most initiatives were supported by diverse funding sources. For example, of the 36 initiatives that identified funding sources, 26 of them (72%) reported using funding from outside the child welfare system. Consistent with findings in 1998, Medicaid and mental health funds were the most likely sources of funds to be used in combination with child welfare funds to support the initiatives. The use of TANF funds was on the increase. In 1998, less than 17% of the initiatives included TANF funds, compared to 30.6% in 2001. There is, however, a continuing downward trend related to the use of substance abuse and education funds in these initiatives. In 2001, only 11.1% of the child welfare initiatives reported that they used substance abuse funds, despite the need for access to early intervention and treatment services, especially for the parents of children served by the child welfare system. This level is a slight decrease from the 1998 finding, in which 13% of the initiatives reported using substance abuse funds. Education funds were the least likely funds to be used in the initiatives.

There was a slight increase in 2001 in the number of initiatives that were described as Integrated Systems of Care projects. In many instances, projects were initiated with various federal and foundation planning funds with the explicit purpose of integrating services across public systems, maximizing federal revenue, and creating seamless and flexible systems for children served by public agencies. Many of these new models are publicly managed but with innovative privatized contract arrangements that also create incentives at the service level.

Risk-Based Financing Options

Finding

Over 90% of the child welfare initiatives include changes in financing or payment practices to create incentives for performance. Many initiatives include more than one mechanism to align payment with desired results.

As in previous years, the CWLA 2001 survey revealed significant variations in financing arrangements among the child welfare initiatives. The arrangements may even vary within the same initiative over time or between different county initiatives within the same state. The level of risk ranges from global budget transfers, to capped allocations or capitation, to case rates, to discounted Fee-For-Service or per diem arrangements that include bonuses and/or penalties based upon performance or case milestones.

Each of these options, as it is typically used in child welfare, is described below.

Capitation, Capped Allocations, & Global Budgets

In the purest managed care financing model, a contractor is prepaid a fixed amount for all contracted services for a defined, enrolled population on a monthly basis. This per member, per month, population-based payment arrangement is referred to as capitation. In this type of arrangement, the contractor is at risk both for the number of children who use services and for the level or amount of services used. The contractor receives the predetermined amount based on the number of enrolled children regardless of the number of children who actually use services or the level of services that enrolled children require during the month. If the contractor enrolls children who subsequently underutilize services, the contractor will make a profit. Conversely, the contractor is exposed to significant financial risks if the plan is not adequately priced or if the eligible enrolled population uses more services or more costly services than projected.

There are a number of reasons cited by child welfare administrators for not extensively using pure capitation models in child welfare. Part of the challenge has been the lack of accurate data that can be used in an actuarial model to project for the general population what percent will require services from the child welfare system, at what level, for what period of time, and at what cost. Another serious challenge is the relatively small number of children who will be enrolled as compared, for example, to covered lives under a public sector managed health care plan, making capitation for child welfare very risky.

Several public agency child welfare initiatives include reimbursement methods that resemble capitation. For example, in many of the county-administered initiatives, the state provides the county a capped allocation, and the county assumes responsibility for managing and delivering (or purchasing) child welfare services under this block grant. Under such arrangements, the county agency is often also given increased flexibility and control over resources and the ability to retain savings. The county agency may decide to share risks and case management responsibilities with individual service providers or lead

Florida's Global Budget Transfer

The Department of Children & Families (DCF) contracts with twenty-two lead agencies for a fixed dollar amount that approximates the appropriation that district offices previously received to provide all child welfare services with the exception of investigations and the Hotline. Lead agencies are expected to access other funding sources, such as Medicaid for therapeutic services and local funding for prevention. In addition to the funds to support services, DCF transferred administrative and management resources (including capital equipment) to the lead agency based on a calculation of the pro-rata share of public agency positions eliminated as a result of privatization.

Prior to the introduction of lead agency contracts, DCF acknowledged that fiscal inequities existed in its methodology for allocating funds, which resulted in greater allocations to districts that had higher placement rates and longer lengths of stay. Over time, DCF has attempted to more equitably distribute funds and reward performance related to permanency, safety and well-being. Equitable funding is not yet fully evident, resulting in some lead agencies getting higher levels of funding than others.

When fully implemented, there will be over $400 million in contracts with lead agencies.

agencies.

There are also several lead agency models that include financing arrangements that resemble capitation. In Florida, nonprofit lead agencies operate under a global budget transfer. They are given a predetermined percentage of the state's annual operating budget and asked to provide all services, in whatever amount needed, regardless of how many children and families in their geographic area may require services. The allocation is based in part on historic caseload size and previous spending for the geographic area covered and in part on assumptions of how the new privatized community-based care systems will affect future utilization patterns and outcomes.

Case Rates

Finding

The most common risk-based model in child welfare is a case rate.

Under this arrangement, a service provider, private lead agency, or other managed care entity (MCE) is paid a predetermined amount for each child referred. The contractor is not at risk for the number of children who will use services but is at risk for the amount or level of services used. For the contractor, if the case rate amount is adequate, it is a *less risky* financing arrangement than capitation.

In child welfare contracts, the case rate could be episodic or annual. An episodic rate means the contractor must provide all the services from initial entry into the plan until the episode ends. The point at which payments stop and risk ends varies from one initiative to another. However, it is common for the contractor to bear some risk until specified goals are achieved, whether it takes days, weeks, or years. For example, a typical case rate contract for foster care services might extend financial risks for up to 12 months after a child leaves the foster care system. If a child reenters care during that time, the contractor may be responsible for a portion (or all) of the cost of placement services.

Under an annual case rate, the provider receives the case rate amount each year the child is in the child welfare system and the contract is in effect. In both annual and episodic case rate arrangements, the payment schedule could be a monthly per child amount or it could be divided into lump sum payments that could be linked to

Episode of Care Case Rates

The Cuyahoga County, OH child welfare agency uses an episode of care case rate in a pilot that targets a portion of the county's caseload of children, from birth to age 14, who are in specialized foster care or higher levels of care. Only children who have behavioral or health care needs and their siblings are in the pilot. The case rate amount ($50-53,000) was established through an RFP process.

The case rate is designed to cover the period of custody to permanency, plus 9 months (12 months for children who are adopted) and assumes that at least 50% of children achieve permanency within 12 months.

The payment schedule for contractors calls for 18 equal monthly payments for each child/family. The payments are made whether the child remains in care the entire 18 months or longer or achieves permanency sooner. If the child achieves permanency and remains stable for nine months, the financial obligation of the contractor ends. If the child reenters care within nine months of permanency, the contractor must take responsibility for the child's care and services within the original case rate.

attainment of various outcomes. An episode of care case rate is far riskier for the contractor than an annual case rate due to the many factors outside of the contractor's control that may extend the time it takes for the episode to end.

Bonuses and Penalties

As noted with the performance-based contract description, more public agencies appear to be aligning payment schedules and/or payment amounts to outcomes or results.

A number of states with fee-for-service arrangements, case rates, or other financing arrangements are also adding bonuses and penalties based on performance. Initiatives differ widely in the selection of performance measures and in the incentives that are provided. Some initiatives include only bonuses; in others, only penalties; and in yet others, both bonuses and penalties.

A number of other states and counties are experimenting with bonuses, penalties, or both that are added to case rate payments if the provider meets expectations.

Mechanisms Used to Limit Risks and Savings/Profits

Before examining the mechanisms used to limit risks, it is necessary to understand what the risks are. Every fiscal strategy, even a traditional fee for service arrangement, has risks -- the potential for revenues and expenditures to vary. When revenues exceed expenditures, there is a surplus, which can be taken as profit or reinvested in the system. When expenditures exceed revenues, there is a loss. The risks can be found in the number of children who use services, the unit costs, the case mix, the volume, and the duration. Risk-sharing is a function of determining who is responsible for each type of risk. There are different inherent risks associated with each of the previously described risk-based financing options.

Bonuses and Penalties

Cuyahoga County, OH includes penalties but not bonuses in its lead agency contracts. The lead agencies serving children ages 14 and younger must achieve permanency within 36 months for 80% of the children served.

The lead agency serving children 12 and younger must achieve permanency within 36 months for 87% of children served. For every child over the allowable standard who has not achieved permanency, the provider will be fined $3,600.

Ohio Risk and Reward Corridors

In the Cuyahoga County case rate pilot, one contractor has accepted full risk, and the other two have a 10% risk corridor. There are limits on how All contractors use potential retained savings.

In Franklin County, lead agencies are protected from excessive financial risk through the establishment of a stop loss that will pay 50% of direct service costs if total costs for an individual child exceed four times the case rate. The contract also includes risk-reward corridors that prevent lead agencies from gaining or losing more than a set percentage each year. In the first year, the risk corridor was 10% of the total budget, in the second year it was 15%, and in the third year it was 20%.

In the Hamilton County Creative Connections initiative, the arrangement in 2000 with the lead agency included both individual and aggregate stop-loss provisions.

Because of the newness of risk-based contracting, the uncertainty in calculating the rates, and the likelihood that the contractor will be a nonprofit agency with limited capital reserves, most child welfare risk-based contracts also include mechanisms to ensure that contractors remain solvent and stable. The most common mechanism in child welfare initiatives is a risk-reward corridor. In addition to protecting contractors from excessive loss, the purchaser may also limit the contractor's ability to retain profits or savings.

Child welfare purchasers have found other methods of limiting a contractor's risk. For example, some child welfare case rates cover certain services typically reimbursed under Title IV-E funds, but the contractor is expected to bill Medicaid under fee-for- service arrangements to supplement the case rate. Or, in an attempt to better match level of risk to level of need, purchasers might propose risk- adjusted or stratified rates for children with different levels of service needs. Using a similar logic, in a few initiatives the purchaser allows the contractor to be reimbursed outside the risk arrangement on a fee-for-service basis for a certain number of children.

Finding

The majority of contracts that include financial risks for private child welfare agencies also have some mechanisms to limit risks.

In some instances, the contract includes aggregate or individual stop-loss provisions that limit the contractor's losses when expenditures exceed a certain amount for an individual child or for the entire covered population. Another method that is infrequently used in child welfare is a risk pool that can be accessed to cover unexpected costs under specified circumstances. The degree of exposure to risk and the potential for reward can also change over time within the same initiative.

Pricing the System and Adjusting the Rates

Child welfare initiatives have varied in their approaches to pricing the overall system, establishing rates for contractors, timing the introduction of financial risk, and adjusting rates over time. Some child welfare initiatives introduced financial risk during the initial implementation; others phased-in risk after some period of time—often after the first year of cost and utilization data collection and analysis. In some initiatives, the public agency allowed the competitive bidding process to set the price and establish the rates. In other initiatives, the rate was specified in the RFP.

Finding

In child welfare contracts, initial rates have often been developed with inadequate data or risk modeling tools. It appears when rates change based on actual costs the change is more likely to result in increased rates for providers.

In most instances, the overall budget for the initiative is initially based upon estimates of what similar services cost under the traditional system. The risk-based rates are also calculated on the basis of rates paid under per diem and fee-for-service arrangements. Many respondents to the CWLA surveys reported difficulty in accessing accurate historic data to guide them in pricing the system or establishing the rates. For example, few child welfare agencies have had the ability to estimate with confidence the costs of serving a child from entry to exit from the system as a foundation for developing an episode of care case rate. As a result of the initial guesswork, it has

not been uncommon for states to err in pricing the overall initiative or in setting rates, with, at times, mid-course corrections being made.

Anecdotal evidence suggests that at times, rates are adjusted based on state or county fiscal or political factors that do not necessarily reflect evidence of the sufficiency of the rates. In other instances, the changes are made in response to fiscal audits or independent evaluations. For example, as a result of higher than expected expenditures after the privatization contracts were introduced, Kansas undertook an independent audit that revealed the following:[14]

- Start-up issues caused costs and lengths of services to be greater than anticipated. The auditors attributed many of the cost overruns to implementation problems, including difficulty attracting experienced social workers, larger numbers of referrals than expected, key infrastructure problems (including MIS development), and the individual learning curve of each provider.

- The largest variable in the overall cost of services was the type and amount of residential services used. The auditor noted that the renewed emphasis on family foster care appears to be reducing aggregate costs.

- The monthly cost was much greater than the bidders' projected estimates. The auditors estimated that cumulative costs were 65% higher than originally projected for foster care and 13.5% higher for adoption.

Kansas Abandons Case Rates

In February 2000, Kansas abandoned its episode of care case rate approach altogether and instituted a per-child, per-month capitated rate payment system. The Kansas Department stated the following to a legislative oversight committee with regard to the agency's decision to dismantle the case rate system:

"The financial review process created concerns regarding the viability of the case rate as the payment system for foster care. The primary concern was that the contractors did not have adequate control over when children returned home or moved to another permanency [arrangement] to manage their finances in such a payment system. This left the contractors in a situation where their financial risk could not be appropriately balanced with their case responsibility."

As a result of the under-estimation of costs and inadequate case rates, the Kansas foster care lead agencies experienced severe shortages in the first years of operation. By March 1999, one contractor (Kansas Children's Service League) had an operating deficit of $1 million; another (Kaw Valley Center) had a deficit of $6.5 million; and the third (United Methodist Youthville, which subsequently went into bankruptcy in June 2001 and since has reorganized) had a $7.5 million deficit. In an effort to address these issues, the Kansas legislature transferred approximately $50 million from the federal welfare-to-work program to foster care.[15]

Fiscal Assumptions and Actual Performance

While cost containment or the re-direction of resources may be among the goals of the child welfare initiatives, many of the respondents to CWLA surveys indicate that the risk-based features they have incorporated also mirror best practice in child welfare. In fact, fiscal and purchasing changes do not appear to reflect a shift in ideology but rather recognition of the power of financial incentives to change practice.

Although child welfare respondents have rarely indicated that containing or reducing overall child welfare costs is the principal goal of the initiative, most initiatives do, however, have expected budget neutrality and the redirection of resources to provide more appropriate services to more people with the same dollars. In most initiatives, there were built-in assumptions about what effect the proposed change would have on costs. CWLA survey respondents were asked to compare actual fiscal performance data (if available) to fiscal assumptions that were made when initiatives were designed. Based on child welfare respondents report, no one-to-one relationship was found between fiscal assumptions and performance. Some initiatives were not designed explicitly or intended to save money, but they have (Illinois, for example), whereas others were intended to be cost neutral and have, in fact, cost more (Kansas, for example). Only three states expected the initiative to cost more than the previous system, but fiscal performance data indicate that 10 initiatives cost more than the previous system. In some instances, States reported they were pleased with results because funds had been re-directed, enabling more children and families to receive services at the same or slightly more costs.

There is little in the way of comparative analysis of risk-based initiatives with different structural designs to indicate that one structural or financing model is superior to another or, for that matter, superior to traditional contract arrangements.

It is important, however, that a public agency fully understand the pros and cons of each type of risk-based option and the potential opportunities afforded by different structural designs before making decisions. Some of the issues that must be considered are fairly straightforward; others require a full appreciation of how all the design pieces need to fit together to achieve results. It is also important to recognize that the ultimate success of an initiative may relate to many factors separate from the structural model and the risk option chosen.

3. Summary & Commentary

What is clear across published reports is that there is broad interest in privatization; there is great variation in the scope of current initiatives (in terms of geographical reach, target population, the number of clients served, and structural design); there is variation in financing mechanisms but with a common thread that attempts to link improved performance to reimbursement amounts or payment schedules; there are different approaches to defining and monitoring results but most initiatives are focused on outcomes related to state and federal mandates; and, there are mixed findings as to actual success related to effectiveness and efficiency (costs).[16]

Overall, the child welfare privatization initiatives have been consistent in some aspects since they first emerged a decade ago. Public agencies are still partnering predominantly with nonprofit agencies. The driving forces have also been consistent but with a broader involvement of the legislature in more recent years. States appear to be focused on improving quality and are increasingly turning to independent evaluations to confirm results. Risk-sharing arrangements are commonplace, but with new twists that more directly link payment schedules or amounts to performance.

Every child welfare initiative has had to wrestle with basic design and procurement questions relating to the type of risk or results based financing arrangements that will be used and the types of organizations that will be allowed to participate in the bidding process. There appear to

be many reasons why some initiatives succeeded and were later expanded and others failed to achieve fiscal and programmatic goals and were dismantled. At times, plans failed because they had design flaws from the outset or because there was not a balance between expectations, authority for decisions, and resources. It is encouraging that many initiatives appear to focus on increasing family involvement, cultural competency, and wrap-around approaches to service planning and delivery. Less promising is the fact that many states and private agencies still struggle to track basic utilization, cost, and outcome data within child welfare and across other child-serving systems to analyze the effect of various privatization initiatives.

In the past few years, more initiatives have undergone fully independent evaluations. However, the evidence is mixed. For example, the University of South Florida's evaluation of twenty-eight Florida counties in which community-based care (CBC) was operational found great variability in the performance of the CBC sites on different indicators related to safety, permanency, and well-being, in part due to the different stages of the implementation process and in part due to the significant variability in their designs and the level of funding.[17] The overall conclusion about expenditures per child contained good news but also pointed to the need for patience in finding improved results. CBC and non-CBC counties experienced similar average expenditures per child for the first four years of CBC, but not for the last three years, where average expenditures per capita were lower for CBC counties than non-CBC counties. Additionally, CBC counties spent a lower proportion of their total budget on out-of-home care than non-CBC during FY 02-03. The Florida cost findings are similar to those of other independent evaluations, including the Colorado and Kansas evaluations.[18]

In regards to achieving specified outcomes, evidence is promising but still inconclusive in many areas. Again, the Florida evaluation found that the privatized CBC sites performed, for the most part, as well or better than the non-privatized sites. However, there was variability among the CBC sites with some performing far better than others on certain outcomes but poorly, in comparison, on others. The most difficult areas to improve were those areas that are most difficult for public agencies as well——namely, moving children safely into timely permanency without having an increase in re-entry or other undesirable outcomes.

Best Practices in Privatized Case Management Systems

Research studies have identified a number of promising approaches found in various types of privatization initiatives including the following:

- *Wraparound values/principles*. Many initiatives appear to be grounded in system of care principles. For example, the majority of the Florida Community-based Care plans described an approach to case planning and services delivery that reflects core values of cultural competence, family involvement, and individualized plans that addressed identified needs.

- *Family team conferencing*. The majority of initiatives that have included privatized case management require the contractor to use a shared family decision making model to develop and revise case plans. Many initiatives include standards and timeframes for convening teams and completing and revising plans. Providers are monitored to ensure that providers are meeting standards.

- *Evidence-based practices & decision support tools*. A few initiatives have specified a particular practice that the contractor is required to use (MST, for example). More often, the contractor has had to describe the clinical protocols or decision support tools that would be used to ensure quality and appropriate, individualized services. The public agency typically signs off on protocols before implementation.

- *Continuity in case managers*. Under traditional child welfare systems, it is not uncommon for a child and family to have different caseworkers depending on the services and case plan goals. For example, a child might have one caseworker if services are provided in- home and then be assigned a different caseworker if placement is required. If the goal becomes adoption, a different caseworker might take over the case. Under many of the new initiatives, a single case manager (or a case management team) is assigned to the case and the same caseworker retains responsibility from the time of assignment until achievement of permanency and case closure. Specialists might be assigned to assist the worker (adoption or independent living specialists, for example), but the child and family experience continuity in case management from entry to exit. This model is the dominant model in Florida.

- *National accreditation standards*. A number of states require contractors to be accredited by a national accrediting body (COA, CARF, JACHO) and they mandate that nationally recognized caseload standards be met. (It is not clear in some cases that the funding is sufficient to support the required caseload standards.) Florida, Kansas, Missouri, and Illinois, for example, require accreditation.

- *Expanded services through community service networks*. An explicit goal in nearly half of the initiatives described by CWLA was to expand the current array of services available to children and their families through the creation of a provider network. Often, the public agency specified the services and supports that had to be included in the network but allowed the contractor flexibility in developing network standards and contracts with service providers. In some instances, the private agency that is responsible for case management is also responsible for network development. In other instances, the case management agencies and agencies responsible for network development are different and are linked by contracts or interagency agreements.

- *Improved use of technology*. As noted previously, while many initiatives still struggle to build and maintain adequate IT, many have built capacity that has resulted in improved data collection and use of data at the case level and as a guide for future system improvements. With better data on outcomes and costs, many initiatives have succeeded in getting additional support from legislators.

- *Added training and supports for caregivers*. Many initiatives have given extra attention to recruiting and supporting caregivers (foster, adoptive, and kinship families). Many have added formal and informal supports, including additional respite, bonuses for recruiting other families, mentors or resource families for new families, and networking/communications mechanisms.

In summary, while privatization may offer real opportunities to improve results, the development and implementation of these arrangements present a host of challenges.

Challenges[19]

In order to better understand initiatives of particular relevance to Arizona's focus, in September 2005 interviews were conducted with private agency child welfare executives responsible for different types of case management services in five states. The sites were selected to represent the most common types of initiatives described in previous studies—namely, those involving case management and services for children and youth in or at risk of out-of-home care and those with adoption as a permanency goal. The interviewees noted a number of challenges that were similar across the different projects and consistent with national research including the following:

- *Inadequate data collection and analysis capability*. Data are needed to guide decisions about the structure, programmatic directions, and financing methods; to develop appropriate outcomes and benchmarks; to assess whether those outcomes/benchmarks are being met; and to make decisions regarding needed changes. Typically, neither the information systems nor the data they produce are adequate for the public purchaser or for the contract providers, especially those operating under risk-based contracts. Data collection and analysis was an area of concern for three of the five agencies interviewed (MS, FL, KS).

- *Lack of role clarity between private agency case managers and public agency staff*. Public agencies do not relinquish legal responsibilities when they enter into contracts. It has been difficult in many initiatives to find the right balance in public and private agency roles and responsibilities. Efficiency has been undermined because the public and private sector roles were not clear or were duplicative. Private agencies have been placed in untenable positions under risk-based contracts when they do not have control over key decisions that impact risk. This issue was raised by four of the five interviewees (MA, MO, OH, and KS).

- *Inadequate service capacity*. Without adequate and appropriate services, privatization is not likely to achieve, safety, permanency, or well-being goals regardless of the management, contracting, or financing model. Yet, in many cases, the contractor has not had the authority or resources to fill service gaps that pre-dated the initiative. Resources outside of traditional child welfare funding sources are often needed to build the capacity needed. Lack of service capacity was an issue for four of the five interviewees (MA, MO, OH, FL).

- *Poorly defined or the wrong outcomes*. The importance of outcomes in privatization efforts has been emphasized consistently. However, it is not always evident that outcomes included in contracts are the *right* ones or that they are defined in ways that are meaningful or measurable. Challenges related to outcomes were raised by three of the five states (MA, MO, Fl).

- *Resources that are not aligned with expectations*. When public agencies develop their privatization plans, the performance expectations are often higher than performance in the current system, while the resources are the same or less, making it difficult to achieve either programmatic or fiscal goals. This struggle was of concern to two of the five interviewees (MO, KS).

- *Problems with financing*. Significant variation exists in financing arrangements, with various approaches to pricing the initiative, establishing rates, timing the introduction of financial risk,

and adjusting rates over time. Issues arise in relation to the underlying sources of funding, the fiscal methodology, and the mechanisms to address the potential impact of risk-sharing. After a decade of experimentation, there is still no compelling evidence of the efficacy of one financing approach over another. Recent evidence might indicate that the dominance of the case rate may be giving way to other performance-based contracting options. Challenges related to financing were raised all interviewees.

- *Lack of private agency expertise in family-centered practices, evidence-based innovations, or new business processes*. A downfall of many initiatives is the lack of knowledge or experience of the private agencies in managing risk, creating provider networks, introducing appropriate utilization management, adapting and using protocols and decision support tools to better match services to needs and improve services, and meeting the requirements of legal mandates that are at the heart of child welfare case management. Program and business expertise was an issue for all of the executives interviewed.

- *No magic bullet for staffing*. Private contractors have had to come to terms with the same challenges the public agency faces -- namely the difficulty recruiting, supporting, and retaining workers and caregivers. Three of the five executives raised this as a primary concern.

- *Lack of understanding of legal issues and experience engaging the courts*. Significant difficulties have arisen when privatization plans failed to recognize the need for judicial buy-in. Court-related issues are especially important for public agencies to consider when balancing the level of risk with the degree of autonomy contractors have in decisions that affect risk. The Kansas experience with the initial launch of privatization should have been a clear warning for other States. Unfortunately, this issue continues to be a challenge in many initiatives. In other initiatives, as noted in the case studies, even though the case management is privatized, many states have ensured that the public agency's legal staff remain in place and in some instances, the public agency staff attend hearings with the private agency case managers.

Various researchers using different methodologies have identified additional challenges, including the following:

- *Limited funding sources fail to meet complex needs*. Despite the higher prevalence of poor physical health and mental health and substance abuse issues among children and families, many privatization contracts are funded primarily with child welfare funds and have failed to include arrangements for accessing health, dental, and behavioral health services that fall outside the contract. This funding issue has been a challenge for Florida CBC agencies and the solutions have varied.

- *Adherence to rigid procedures*. By accident or design, some projects have struggled because there were inherent barriers to innovation. Contracts often require adherence to day-to-day operating procedures required of public agency staff that were not flexible enough to allow contractors to succeed. Simply changing from a public agency to a private agency will not result in improved outcomes or efficiencies.

- *Flawed contracts*. In many initiatives, the RFPs and contracts are fraught with problems. In some cases, expectations are framed in ambiguous terms, making it impossible to determine what the private agencies were expected to do, what clients were expected to receive, and what results were to be produced. According to Madelyn Freundlich, "In sum, in many privatization initiatives, the dynamic was one of an inexperienced purchasing agent attempting to develop at-risk contracts with inexperienced sellers."[20]

- *Overdone or underdone monitoring*. Most public agencies have struggled to find the appropriate level of monitoring and oversight. Researchers have noted a tendency for micro-management in some initiatives, while in other initiatives, the level of monitoring seems woefully inadequate. Over time, the public and private agencies in many Florida CBC sites have struck an appropriate balance and have created some promising practices that merit further study. The HFC case example in Appendix 1 describes the model used.

- *Limited consumer involvement*. Organizations that have studied the essential features of privatization consistently have highlighted the importance of consumer involvement. Though it is a value articulated in most RFPs and contracts, it is unclear whether (and how) consumer involvement is actually occurring in the planning, implementation, monitoring, or evaluation of child welfare privatization.

- *Lack of attention to cultural & linguistic competence*. Nationally, systems of care for children are attempting to respond effectively to the needs of children and families from culturally and linguistically diverse groups. Again, though a principle in all child welfare policies, it is unclear whether cultural and linguistic competence is being considered or is improving under child welfare privatization. Given the large Native American population in Arizona attention to cultural competence and engagement of the Indian Tribal Councils would be particularly important.

Lessons Learned & Advice from the Field

As depicted in Table 1, the structured interview protocol for private agency executives in five States asked the executives to prioritize the most important issues for both public and private agencies to consider in planning for a privatized case management system.

Table 1: Advice from the Field

Initiatives	Advice
What are the top three things public agencies should consider in contracting for case management?	
Massachusetts Commonworks	1. If both public workers and private agency case managers have case management responsibilities, make sure there is clarity in public and private roles. 2. Make certain that the public agency retains the responsibility for legal services. 3. Include fiscal incentives aligned with results -- but make sure you have IT and quality assurance capacity to monitor both costs and outcomes.

Initiatives	Advice
Missouri Interdepartmental Initiative	1. Build a real partnership with the private sector to get the political clout needed for hard times. 2. Make sure the financing option gives flexibility in funding and specifies the outcomes/results desired. 3. Require accreditation as an added protection for quality.
Cuyahoga County, OH. *Case Rate Pilot*	1. Get "buy in" from all levels of the public agency staff. 2. Clearly define roles and responsibilities between the county staff and the case management organization. 3. Have mechanisms to avoid and manage the risk of abuse and neglect of children while in the system.
Florida Lead Agency Heartland for Children	1. The importance of data accuracy, accessibility, and integrity. 2. The complexity of financial reporting (merging governmental accounting into traditional non-profit accounting systems). 3. The importance of strong leadership and the requirement of critical, analytical thinking to ensure viability of the lead agency.
Kansas Privatized Adoption, foster care, and in-home	1. The impact on federal requirements for documentation. 2. Knowledge of expenses (including direct and indirect costs) 3. A plan to develop "buy-in" from all stakeholders
What are the top three things private agencies should consider in developing the capacity to provide case management services?	
Massachusetts Commonworks	1. Look at this as an opportunity but also recognize what you don't know and hire the people who know case management from the public agency perspective. 2. Look at staffing: recruitment, training, and then build capacity to respond to the public agency's need for immediate responses. 3. Have an attorney review liability issues and prepare the Board.
Missouri Interdepartmental Initiative	1. First, they need to build the expertise. Start by hiring experts to guide them through all they don't know about the system's obstacles. 2. Get a handle on costs and if the money isn't there, don't bid. 3. Philosophy of care. Many providers will need to embrace family-centered practices, build child/family strengths that will help to achieve permanency, while also acquiring new business tools & skills.
Cuyahoga County, OH. *Case Rate Pilot*	1. Make sure that they have enough referrals that fit the project criteria -- Is the target population big enough? 2. Understand risk. Risk can be created by actions outside of the control of the case manager (*ie*: court, school). 3. Make sure they have the services that will meet the needs of the population that will be included.

Initiatives	Advice
Florida Lead Agency *Heartland for Children*	1. Prevention capacity- Prevention is an investment strategy. When properly administered, it will realize cost avoidance. 2. Service capacity- Utilization Management is a core business strategy in the system of care to manage resources, increase choice and promote cost efficiency. 3. System capacity- A true "system" of care includes the best characteristics of structure, process, subsystems, information, growth and integration.
Kansas *Privatization of foster care, in- home, and adoptions*	1. The private agency needs to have an MIS system that captures the type of data that is needed to track cases and provide fiscal and other management reports. 2. A utilization management system which authorizations of all out of home placement and services and payment. 3. Be prepared to pay mid-level managers higher than average salaries.

Key Success Elements

Based upon national research findings and the interviews with private agency executives, key factors for success, across different designs, appear to relate to the sophistication of the purchaser in planning, procurement, and contract oversight; the alignment of resources with expectations; the adequacy of funding and contractor rates; the buy-in from stakeholders; the care with which system designs were developed; the clarity and appropriateness of the expected outcomes; and the infrastructure, leadership, and innovation of the contractor and the public purchaser. Successful privatization initiatives share a few essential characteristics in common with effective public agency programs, including the following:

- Strong and steady leadership
- Clear vision, goals, objectives, and performance criteria.
- Sufficient staffing and other resources to implement the vision
- Continuous and meaningful performance monitoring
- Specific, measurable outcomes
- State-of-the-art information systems that allow private and public service providers to track progress and outcomes
- Strong and committed leadership
- Resilient interpersonal working relationships between public and private agencies
- Strong ties to the communities they serve
- New business tools and innovative practices.

It seems clear that privatization is best implemented through a broad-based planning process that engages stakeholders in a sustained dialogue for the purpose of reaching consensus on the goals of the privatization initiative. Reaching agreement on difficult decisions later in the planning process will be far easier if all parities are united in a shared vision.

At the outset of planning for privatization, it is also important for policymakers and decision makers to recognize that positive results will not be immediately evident. States should not expect to save money through privatization——at least not in the short-term. Greater efficiency and improved outcomes for children and families will not be achieved simply because private agencies assume primary responsibility for case management but rather because all of the agencies involved are committed to working together over the long haul to identify and remove barriers that stand in the way of achieving a shared vision.

Privatization Continues to Evolve

While the previously described national trends information accurately reflects research on initiatives that were underway at the time the studies were conducted, it is important to note that initiatives are not static. Changes may be made in financing arrangements or in the overall design of an initiative when it becomes clear that the contractor does not have control over the factors that result in unacceptable risks or when results are not as expected. As states and contract agencies fully assess the costs and benefits of their financing and contracting arrangements, it is not unusual for State and local initiatives to alter their initial plans. Some initiatives that were included in the CWLA 2000-2001 survey report, for example, have made significant changes in various aspects of the model subsequent to the 2003 report. Several initiatives, selected from the 39 described in the CWLA report, are highlighted to illustrate the types of shifts that have occurred:

- ◊ In Missouri, child welfare functions are the responsibility of the Division of Family Services (DFS) of the state Department of Social Services (DSS). DSS also includes the Division of Medical Services (Medicaid) and the Division of Youth Services (DYS) for juvenile corrections. There is a separate Department of Mental Health (DMH). In 1997, the then-Directors of DSS and DMH formed the Interdepartmental Initiative for Children with Severe Needs with funding from The Robert Wood Johnson Foundation, the Center for Health Care Strategies, and pooled funding from dollars provided by DSS and DMH. At the end of the original contract period (February 2002), two of the original Initiative agency partners elected not to participate in the contract extensions. DMH, citing budget difficulties, withdrew, as did DYS, which believed that it already provided the services provided by the lead agency. These developments occurred shortly after the departure of the DSS and DMH Directors who were responsible for the creation of the Initiative.[21] While the initiative continues with the original contractor (through six contract extensions), the blended funding is now reduced to Medicaid and child welfare funds. The contract is due to expire at the end of 2005 and with a new performance-based contract reform underway, the future of the Interdepartmental Initiative is unclear. It appears that in the latest privatization effort in Missouri, the State has taken core elements from the previously described Illinois model.

- ◊ In Hamilton County, Ohio, an inadequate case rate caused the contractor (Beech Acres) to use its own endowment to subsidize (more than $ 10 million) an interdepartmental system of care initiative that targeted cross-system children with complex needs. At the time of renewal, Beech Acres' refusal to accept a continuation of what it believed was an inadequate case rate ultimately led to termination of contract re-negotiations.[22] The county re-bid the initiative and a new provider (from out-of-state) took over the contract.

- ◊ The Franklin County, Ohio Children Services Project was based on the Franklin County Children Services (FCCS) agency agreement with the county Alcohol, Drug Abuse, and Mental Health (ADAMH) Board and was intended to facilitate better access to behavioral health services by children and families in the child welfare system. The agreement fell apart in 2002. Several reasons were given for the termination of the ADAMH agreement. Among other issues, a recent case study, cited ongoing underfunding of the ADAMH Board and the arrival of a new ADAMH director who did not support the agreement.[23]

- ◊ The Permanency Achieved Through Coordinated Efforts (Project PACE) initiative in Texas, managed by the Lena Pope Home, targeted children with therapeutic needs and their siblings who entered the foster care system from counties that surround Fort Worth. At the time of the CWLA survey, the contractor was expecting to serve approximately 500 children with a budget of approximately $14M under a fixed rate contract of $77/day per child, regardless of the level of out-of-home care. The project was dismantled shortly after the CWLA survey report was published. More recently, in 2004, Governor Rick Perry declared the condition of the system an emergency issue and called upon the 79th Legislature to act decisively to provide the resources and reforms. Senate Bill 6 established a framework for reform by requiring among other things that the Department to privatize substitute care and case management services.[24]

- ◊ The *Commonworks* initiative in Massachusetts was one of the earliest case rate lead agency models that served children with intensive needs. The original financing was no-risk for 18 months to allow the agencies and the State to track actual costs and outcomes. The case rate that was introduced was based upon that assessment. In recent months, *Commonworks* has been dissolved and absorbed by a new initiative. The previous case rate (that also included bonuses and penalties) has been abandoned for a non-risk cost- reimbursement model solely for case management services, with direct services being reimbursed by the State agency. (The model is described in Appendix 1)

It is unknown how many other initiatives reported by CWLA or other research projects have modified their original privatization project. Some of the early initiatives were abandoned due to changes in the State's overall priorities, changes in leadership, or a natural evolution brought about by increased knowledge about what worked and what did not. Some initiatives introduced strategies to ensure sustainability in the face of leadership changes or economic downturns, including creating legislatively mandated bodies to oversee the initiatives, serve as a voice for the community, and identify and access the resources needed to support the initiative. Florida is a good example.

Community Alliances In Florida

Community Alliances are charged by statute with a number of responsibilities including local needs assessment and establishment of priorities; determining outcome goals; serving as a catalyst for resource development; advocacy; and promoting prevention and early intervention services. (Florida Statute §20.196[b]).

Research has helped to identify both promising approaches and challenges in various current initiatives across the country. However, it is important to recognize that privatization is continuing to evolve and with each evolution there are new lessons to be learned.

PART II. CURRENT PERFORMANCE, CAPACITY, AND INTEREST IN PRIVATIZATION

Laws 2005, Chapter 286 (SB1513) requires the Department of Economic Security (DES) to "submit for review by the Joint Legislative Budget Committee options for the privatization of portions of the case management duties for child protective services." In response to this requirement, an assessment of Arizona's readiness to expand its current privatization efforts to include case management services was completed in October and November 2005. The assessment is based upon findings from focus groups, stakeholder surveys, interviews, and document reviews (including procurement procedures, performance reports, the Governor's CPS Reform Initiative, the Blueprint for Realigning Arizona's Child Welfare Program, and various DES evaluations, including those conducted by the Arizona Auditor General).

This section has three parts: 1) an introduction to the readiness assessment process and current DES organizational structure and activities; 2) the results of surveys and focus groups and interviews conducted over a two-week period in October 2005; and, 3) a summary of overall findings.

1. Introduction

The assessment of DCYF readiness involved focus groups, surveys, and interviews with the DES Director, a District Program Manager, Central Office Administrative Staff, child advocates, and legislative staff members.

Twenty-two focus groups were held with 205 individuals who also completed surveys that posed a range of questions regarding privatization. The focus groups and surveys were designed to assess the level of understanding of privatization, perceptions about challenges and opportunities, and views about current DCYF performance and its capacity for privatization, and to identify the issues that stakeholders felt were most important for Arizona policymakers to consider in weighing privatization options. The individual interviews were designed to develop an understanding of current DES operations and the scope of current privatization and to examine some of the administrative areas that are critical to management of privatized contracts, including but not limited to IT, fiscal, procurement and monitoring, and quality assurance capacity.

In addition to these information gathering efforts, an extensive review of documents was conducted. These documents included procurement procedures, internal performance data, external DES evaluations, a number of reports produced by the Arizona Auditor General, and various reform plans, including the recently released *Blueprint for Realigning Arizona's Child Welfare System*.

DES Organizational Structure

DES is divided into nine divisions, including six program divisions, three administrative divisions, and a Central Administration that includes the Director's Office.

The Division of Children, Youth and Families (DCYF) manages child protective services, including

child protective investigations, foster care services, kinship care, independent living services for young adults, adoption services, in-home family services, intensive family services, and substance abuse treatment services for families whose children are at imminent risk of out-of-home care.

Arizona's fifteen counties are divided into six regions, which are referred to as districts, with a total of 64 offices. District I (Maricopa County, including the city of Phoenix and surrounding cities) and District II (Pima County, including the city of Tucson) are the urban districts; Districts III through VI are rural districts. Each district provides:

- Investigation of child protective services (CPS) reports
- Case management
- In-home services
- Out-of-home services
- Contracted support services
- Permanency planning
- Foster home recruitment and training
- Adoptive home recruitment and certification

The Statewide Child Abuse Hotline is centralized for the receiving and screening of incoming communications regarding alleged child abuse and neglect. Incoming communications are centrally screened to determine if the communication meets the definition and criteria of a CPS report. Report information is triaged to determine risk of harm to the child and to establish a response timeframe. Reports are investigated by Child Protective Services Specialists or referred to other jurisdictions (such as tribal jurisdictions) for action.

Central Office functions for the Division and the Administration include:

- Policy and program development
- The Promoting Safe And Stable Families Program
- Finance, budget and payment operations
- Statistical analysis
- Field support
- Interstate Compact On Placement Of Children
- The Child Welfare Training Institute (CWTI) for initial in-service staff training, ongoing/advanced staff training, and out-service and education programs
- New initiatives and statewide programs
- Contracting and procurement
- Continuous quality improvement
- Management information system/automation

According to the DCYF, in fiscal year 2005, there were 1,793 authorized full-time equivalent (FTE) positions, of which 1,023 were CPS specialists and supervisors.

Current Reform Efforts

As a result of Governor Janet Napolitano's Child Protective Service (CPS) Reform Initiative and funding support from the Arizona legislature, Arizona has made significant system improvements in recent years, especially in the areas of intake and investigations and case planning. At the same time, the number of children in out-of- home care increased 37% in the two-year period between March 2003 and March 2005. The number of children in out-of-home care increased by an additional 3% between March and June 2005.

Nearly 10,000 children are currently in out-of-home care in Arizona, with approximately 15% placed in group care and 8% in residential treatment centers or shelters. These numbers suggest a system that is overly-reliant on out-of-home care as a service option. The numbers suggest also an under-reliance on community-based services to support and strengthen families and meet the needs of children, youth and families in their own communities.

In response to the challenges that it has identified in effectively serving children, youth and families, DCYF, in partnership with private agencies, is in the process of implementing practice improvements in a number of areas. The following are among the current goals and strategies:

- ◊ Keep children safe in their own homes through the implementation of a comprehensive in-home services model that includes intensive and moderate levels of service based upon the needs of the child and family. The model includes collaborative partnerships between CPS In-home Specialist Units, contracted service providers, Behavioral Health Services, and other community organizations. In-home services are being gradually implemented across the state, beginning in Maricopa and Pima Counties.

- ◊ Promote reunification through the implementation of a Title IV-E waiver that allows for flexible funding to support reunification efforts through intensive support and wraparound services. DCYF is partnering with contract providers to deliver individualized reunification services in select sites in Maricopa County.

- ◊ Build capacity to place children in family-like settings through targeted recruitment in all communities. DCYF currently contracts for foster and adoptive family recruitment from a number of private agencies. An RFP is due to be released that will include expectations for contract agencies to provide resource families on a 24 hour basis for children needing placement.

In addition to the collaborations with private service providers to enhance and expand services, DCYF has a number of other initiatives underway to foster family-centered practices, enhance staff training, and promote integration of services, including the following:

- ◊ Enhance family-focused practice through the implementation of "Family to Family." With support from the Annie E. Casey Foundation, implementation is being phased into various Maricopa County offices with possible expansion to Tucson.

DES is implementing three family engagement models: 1) Family Team Decision Making (FTD) for the purpose of making an immediate placement decision; 2) Family Group Decision Making for the development of a plan to safely return the child home or place the child with a relative; and 3) Child and Family teams for the purpose of developing a behavioral health plan.

◊ Foster increased service integration through co-location of DCYF staff with JOBS, TANF, and domestic violence staff support to create Family Connections Teams to address poverty, kinship care support, and family violence. Teams are in place in Maricopa and Pima Counties.

◊ Eliminate the disproportionality and disparate outcomes for children of color through participation in the Casey Family Program "Breakthrough Series Collaborative," an effort being initiated in Maricopa County.

◊ Provide family-centered substance abuse services to parents of children in or at risk of foster care through the Arizona Families F.I.R.S.T (AFF) program.

Some of these reforms have been fully implemented; others are being gradually phased in; and others are in the planning phase.

As noted, DCYF has a history of working collaboratively with private agencies to solve complex problems. In many of the new initiatives private agencies have partnered in planning the initiative and are providing services under contract with DCFY.

2. Listening to Stakeholders: Surveys & Focus Group Findings

Twenty-two focus groups were conducted with stakeholders in District 1 (Phoenix), 2 (Tucson), 3 (Flagstaff), and 5 (Payson and Casa Grande). There were three types of focus groups: (1) internal DCYF staff, (2) private agency service providers, and (3) external stakeholders (non-provider). As indicated in the following tables, there were 205 respondents to the surveys, including 107 DCYF staff (52%), 56 external stakeholders (27%), and 42 providers (21%).

Participants in the DCYF focus groups included CPS Specialists, Supervisors, Assistant Program Managers, and District Program Managers with responsibilities for the Hotline, CPS Investigations, in-home case management, out-of-home case management, adoptions and adoption and guardianship subsidies, and independent living services.

Focus groups with providers included child welfare and behavioral health providers who provide services to children and families in the child welfare system.

Focus groups with external stakeholders who are not private agency providers included parents (birth, kin, foster, and adoptive), CASAs and Foster Care Review Board (FCRB) members, representatives from other State agencies or divisions and the Judiciary, advocates, and Tribal leaders.

Table 2: Types of Non-Provider External Stakeholders Participating in Focus Groups

External Stakeholders	N	Percent
Parent or Kin Caregiver	5	9%
Foster or Adoptive Parent	10	18%
FCRB or CASA	11	20%
Judicial	5	9%
Other State Agency or Division	17	30%
Child Advocate	1	1.8%
Community Interest	2	3.6%
Other (4 Tribal, 1 Judge)	5	9%
Total	56	100%

Table 3: Types of DES Staff Participating in Focus Groups

Position	N	Percent
Human Service Workers, CPS Specialists, and CPS Program Specialists	70	66%
Unit Supervisors	30	28%
Assistant Program Manager/Deputy Program Managers, and District Program Managers	6	6%
Total	106	100%

The provider participants included agencies with large DES contracts (in excess of $10 million annually) and those with contracts of less than $1 million annually. Some of these participating providers were heavily dependent upon DES contracts; others had contracts that represented only a small percent of the agency's overall budget.

Table 4 breaks out the agencies by contract size and percent of budget. Data from 24 agencies (57%) is included. Eighteen agencies (43%) did not provide budgetary or contract information.

It is important to note that the survey asked about DES contracts and not specifically about DCYF contracts.

Table 4: DES Contract Amounts of Participants & Percent of Overall Budget (N=24)

Contract Tot.	N (% of participants)	N	DES contract as percent of agency budget
< 1 million	5 (21%)	3 1 1	< 10% 10-25% > 90%
1-2.9 million	7 (29%)	3 1 1 2	<10% 25-50% 52-65% > 90%
3-4.9 million	3 (12.5%)	1 1 1	10-25% 26-50% 51-65%
5-6.9 million	0		
7-9.9 million	3 (12.5%)	1 1 1	26-50% 66-80% > 90%
10-12.9 million	1 (4%)	1	26-50%
>13 million	5 (21%)	1 3 1	26-50% 51-65% 66-80%

Most of the focus group participants had a longstanding relationship with DES. Sixty-five percent of external stakeholders have had a relationship with DES for over 5 years; 55% of providers have provided services to DES over 5 years, and 59% of DCYF staff reported being employed with DES for over 5 years. Nearly a quarter of all respondents reported employment, contractual, or other relationship with DES for over 15 years.

Survey Findings

Focus group participants completed a survey prior to the focus group discussion. Slightly different versions of the survey were used with different types of stakeholders but many of the questions were the same, allowing for comparisons within and across stakeholder groups. Survey instruments are included in Appendix 2.

The following findings reflect the information provided by survey respondents. Key issues and themes that emerged in the focus group discussions and individual interviews are summarized at the end of this section.

What Does Privatization Mean?

The survey asked respondents to describe what the term privatization means. Fifty-five (27%) of the 205 respondents did not answer the question or indicated they did not know what privatization meant. As evidenced by the examples in the textbox, the majority of stakeholders defined key elements of privatization, with an understanding that it referred to a contractual relationship between DES and a private agency that shifted responsibility for a function or service previously provided by DES to a private contractor.

The Meaning of Privatization

Providers:

- Contracting with a for-profit or not-for-profit company to deliver services formerly provided by the public agency.
- Using the private sector, both sectarian and nonsectarian, to minimize government involvement in the lives of families.

Other External Stakeholders:

- Giving up control to profit.
- Private industry is contracted to do a job and they are held accountable for an acceptable outcome.

DCYF Workers, Supervisors, Managers:

- Less money, more confusion between different agencies, fragmented systems
- A business approach to social work
- The potential loss of my job

There were notable differences in the tone of definitions offered by DCYF staff and providers. As the examples illustrate, providers tended to set a neutral or positive tone; no provider addressed the potential loss of public sector jobs. DCYF staff, on the other hand, were far more likely to highlight potential negative consequences, especially the loss of jobs. DCYF staff also mentioned their negative experiences working with for-profit managed behavioral health organizations and under-resourced nonprofit agencies as evidence that privatization would not work for child welfare. External stakeholders that were not providers held a mix of positive and negative opinions about privatization.

What Are the Benefits of Privatization?

Respondents were asked an open- ended question about the possible benefits of privatization. Overall, 122 of the respondents (60%) identified one or more possible benefits of privatization. More than one-half (56%) of DCYF staff and external stakeholders (57%) and close to three quarters (71%) of providers identified one or more possible benefits.

The identified potential benefits of privatization included: increased flexibility, particularly with respect to "red tape" and personnel matters; greater competition and enhanced consumer participation; better quality and more effective service; enhanced coordination with other local agencies leading to greater continuity of care; increased cost- effectiveness and administrative efficiency; increased professionalism; the promotion of innovation; greater ability to alter or terminate programs; and local investment in the governance process, which results in a better adaptation of the service system to local circumstances and increased local accountability.

As illustrated in the textbox, all types of respondents cited similar types of benefits. Relatively few, however, mentioned the three most widely cited reasons that public administrators (particularly those who move to performance- or results-based contracts) give for privatizing services: improved outcomes for children and families, the introduction of evidence- based

practices, and increased accountability.

Respondents offered contradictory views about the impact of privatization on costs. Some cited lower salaries in the private sector that would result in cost savings, and others pointed to better salaries and benefits in the private sector that result in increased costs. As noted in the introductory summary of national research, the findings on costs are, in most privatized systems, mixed.

Several respondents noted that families might prefer involvement with a private rather than a public agency and that privatization could provide greater choice and a voice for consumers in the service process. One provider noted that "if contracts are well written, fewer children will be placed in group homes, caseloads will go down, and new practices will strengthen families/ communities."

What are the Biggest Challenges or Barriers to Privatization?

Research studies have documented many challenges or barriers to privatization, including: decreased public accountability and control; difficulties in establishing, maintaining and monitoring performance standards and contractual obligations; unrealized cost savings; declines in service quality or the "skimming" of clients so that the most difficult and needy clients do not receive services; unreliable or ineffective contractors; and, the subjection of private agencies to public policy shifts and budget cuts that threaten the viability and stability of the agency.[25]

Surveys asked respondents to describe possible barriers or challenges to privatization. As the examples in the textbox show, 79% of providers, 72% of DCYF staff, and 64% of external stakeholders listed one or more barriers that were consistent with national research findings.

Benefits of Privatization

- There could be more resources, less hierarchy and less administrative red tape. (DCYF Supervisor)
- The private agencies might be able to start with a clean slate. (CPS Specialist)
- There could be more community support and outside funds from grants. (DES Assistant Program Manager)
- Most private agencies are accredited, have Masters level supervisors, etc. (DCYF Program Specialist)
- No benefits of privatization. Studies show no cost savings or improvement in services. (CPS Specialist)
- More professional employees who have better relationships with foster and adoptive parents. (Foster Parent)
- More specialized services and better trained staff. (Foster/Adoptive parent)
- There could be increased accountability. (FCRB/CASA)
- Families may prefer to work with private agencies as opposed to a state agency. (Other State Agency)
- There could be more money for Tribes and caseloads could go down. (Tribal leader)
- Variety in service providers results in innovation and creativity. (Provider)
- I see a "marriage" of behavioral health/child welfare systems, resulting in a maximization of funding (state and federal dollars) and streamlined processes and access to services. (Provider)
- Private agencies have TALENT and connections to the community. (Provider)

Both public and private agency respondents frequently noted financial concerns, including the beliefs that the system, as it currently operates, is under-funded (and is likely to remain so) and that private agencies, under privatization, would struggle to attract and retain staff and provide quality services.

All types of stakeholders raised liability issues. Providers were particularly concerned about issues related to investigation functions and legal representation for caseworkers in court proceedings. DCYF staff were most concerned with protecting the State's interests when they relinquish control over key case management decisions that impact child safety, permanency, and well-being.

Many respondents focused on the difficulty inherent in changing a "bureaucratic" system, including the resistance to change, the need to build better procurement and monitoring capacity, the mechanics of transferring cases while minimizing disruptions to the child and caregivers, and the impact on morale of a stressed public workforce.

Communication and confidentiality issues and the connection to CHILDS were also concerns. Finally, several respondents mentioned challenges posed by the political climate, the need for strong leadership, and the need for a sound privatization plan.

Which Case Management Services Should Be Privatized?

The survey asked respondents to indicate their level of agreement or disagreement to the privatization of seven different areas of current DCYF case management if they had to choose.

Challenges/Barriers

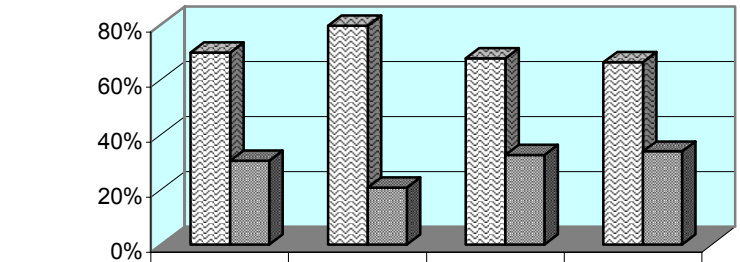
- Small culturally competent providers are unlikely to meet demands of privatization. (External Stakeholder)
- Policies from one agency to another may be inconsistent. (Foster parent)
- How would this work in a rural area where there are no agencies? (Foster parent).
- CPS currently answerable to nobody - will fight to preserve. (Foster/adopt parent)
- Will create overlap and inefficiency. (Judicial)
- Control and management of contract providers. (State agency or other Division)
- How will you gauge success or failure? (External stakeholder)
- Potential for fraud. (Community Advocate)
- Massive change & lack of reliable data to predict the outcomes –- financial and programmatic. (Provider)
- Integration of IT systems with CHILDS. (Provider)
- Training/cross training of private child welfare agency. (Provider)
- Would need current state staff to move to private agencies; how to do this & what would it cost? (Provider)
- Provider's lack of knowledge and expertise. (DCYF worker)
- Hiring & retaining staff at less $$ and benefits than the State offers. (DCYF supervisor)
- Transitioning to privatization without "losing" kids or letting some "fall through the cracks." (DCYF Supervisor)
- Having people and families respect and listen to a non-government agency. (CPS Specialist)
- Monitoring compliance. (DCYF Supervisor)

The case management functions to be considered were: 1) hotline staffing, 2) CPS investigations, 3) in-home case management, 4) out-of-home case management, 5) independent living, 6) adoption, and 7) adoption subsidies.

There were five possible forced choice responses to indicate the level of agreement or disagreement each option. Respondents could: 1) Strongly Agree, 2) Agree, 3) Don't Agree or Disagree, 4) Disagree, or 5) Strongly Disagree. By removing the blank and neutral responses, which represent approximately 27% of all responses, clear agreement and disagreement with each option is more accurately captured. Thoughts of privatizing each case management function evoked both striking differences and subtle commonalities among respondents.

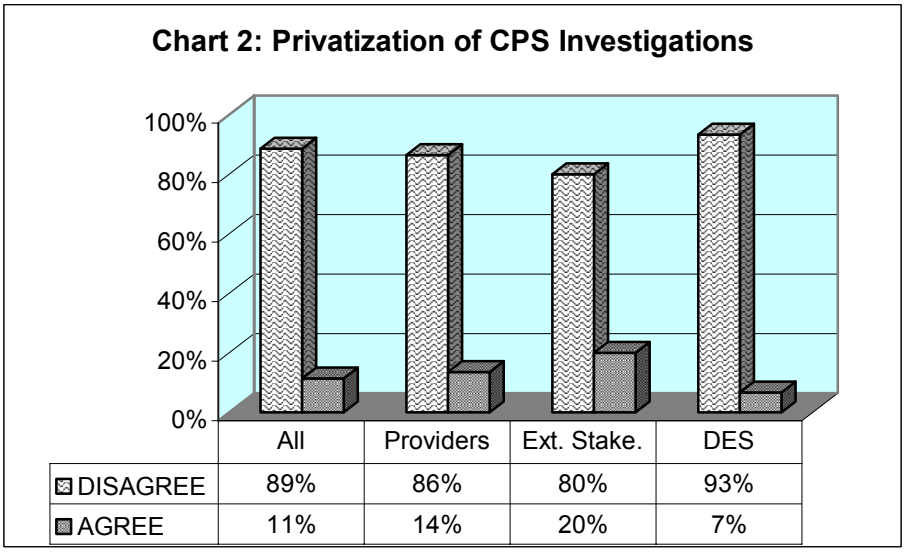
1. I would choose to privatize the Hotline function: Surveys from 57 respondents who either left the item blank or provided a neutral response were excluded from the analysis. Responses from 148 respondents were included, representing over 70% of the total responses. As depicted in Chart 1, the majority (70%) of respondents believed that Hotline function should not be privatized. Providers were most opposed, with 79% *disagreeing* or *strongly disagreeing* to privatization. Approximately two-thirds of both external stakeholders and DCYF staff also *disagreed* or *strongly disagreed*.

Chart 1: Privatization of the Hotline



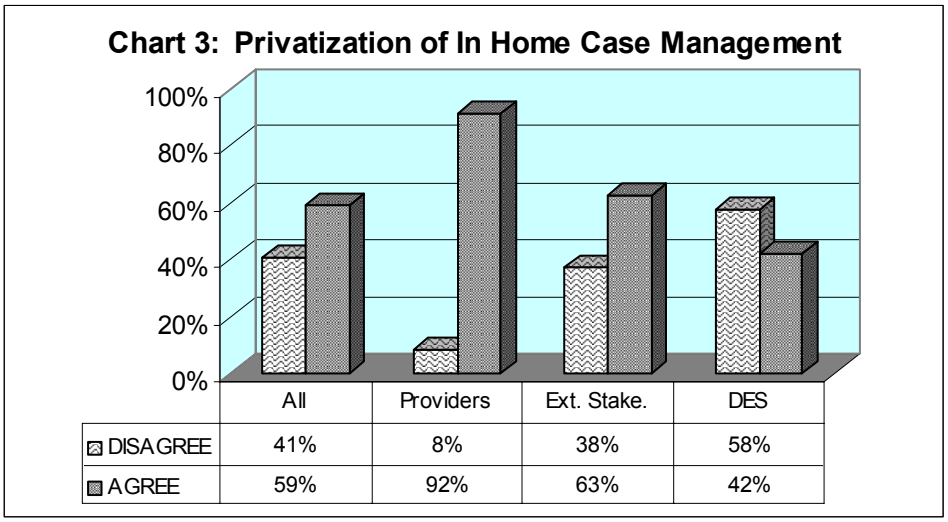
	All	Providers	Ext. Stake.	DES
DISAGREE	70%	79%	68%	66%
AGREE	30%	21%	33%	34%

2. I would choose to privatize CPS Investigations: Surveys from 38 respondents who either left the item blank or provided a neutral response were excluded from the analysis. Responses from 167 respondents were included, representing over 82% of the total respondents. As depicted in Chart 2, the vast majority of respondents (89%) *disagreed* or *strongly disagreed* with the option of privatizing CPS Investigations. DCYF staff were most opposed to CPS investigation privatization (93%); followed by providers (86%); and then external stakeholders (80%).



	All	Providers	Ext. Stake.	DES
DISAGREE	89%	86%	80%	93%
AGREE	11%	14%	20%	7%

3. I would choose to privatize in-home case management: Surveys from 53 respondents were excluded from the analysis. Responses from 152 respondents were included (nearly 75% of the total respondents). As depicted in Chart 3, the privatization of in-home case management elicited very divided responses. Whereas the vast majority of providers (92%) *agreed* or *strongly agreed* with privatizing in-home case management, the majority of DCYF staff (58%)*disagreed* or *strongly disagreed* with that option. A majority of external stakeholders (63%) *agreed* or *strongly agreed* with the privatization of in-home case management.

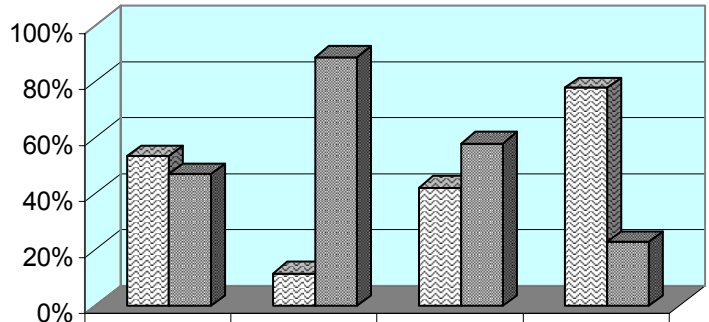


	All	Providers	Ext. Stake.	DES
DISAGREE	41%	8%	38%	58%
AGREE	59%	92%	63%	42%

4. I would choose to privatize out-of-home case management: Surveys from 53 respondents were excluded from the analysis. Responses from 152 respondents were included (nearly 75% of the total respondents). As depicted in Chart 4, the privatization of out-of-home case management elicited almost equal responses at both ends of the spectrum. A slim majority (53%) of all respondents *disagreed* or *strongly disagreed* with the privatization of out-of-home case management while slightly less than half (47%) of all respondents *agreed* or *strongly agreed* with the option. Clear differences were evident. External stakeholders were somewhat

evenly divided in their opinions, with more respondents agreeing (58%) than disagreeing (42%) with privatization. Providers and DCYF staff expressed diametrically opposite opinions, with 89% of providers in *agreement* with privatization of out-of-home case management and 77% of DCYF staff in *disagreement*.

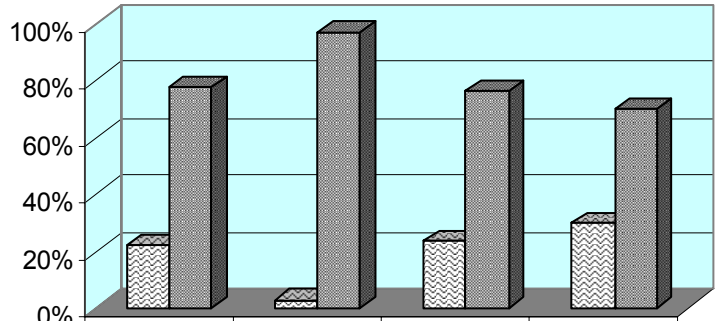
Chart 4: Privatization of Out of Home Case Management



	All	Providers	Ext. Stake.	DES
DISAGREE	53%	11%	42%	77%
AGREE	47%	89%	58%	23%

5. I would choose to privatize Independent Living Case Management: Surveys from 60 respondents were excluded from the analysis. Responses from 145 respondents were included (70%). As depicted in Chart 5, 78% of respondents *agreed* or *strongly agreed* that independent living services should be privatized. Although general consensus existed, provider support (97%) was much higher than that expressed by external stakeholders (76%) and DCYF staff (70%).

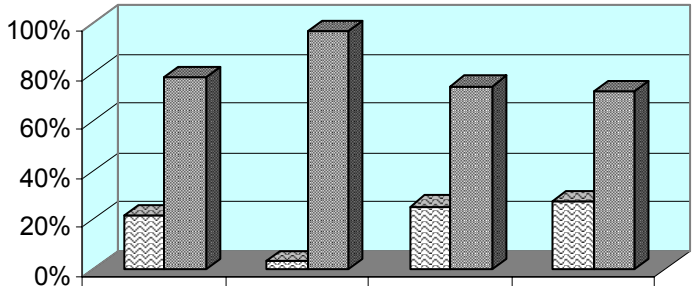
Chart 5: Privatization of Independent Living Case Management



	All	Providers	Ext. Stake.	DES
DISAGREE	22%	3%	24%	30%
AGREE	78%	97%	76%	70%

6. I would choose to privatize adoption case management: Surveys from 55 respondents were excluded from the analysis. Responses from 150 respondents were included (73%). As depicted in Chart 6, 78% *agreed* or *strongly agreed* that they would choose adoption case management as a service. Provider support (97%) for this privatizing this function was again much higher than that of external stakeholders (74%) and DCFY staff (72%).

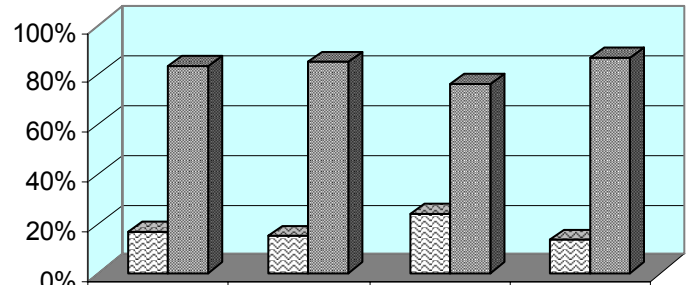
Chart 6: Privatization of Adoption Case Management



	All	Providers	Ext. Stake.	DES
DISAGREE	22%	3%	26%	28%
AGREE	78%	97%	74%	72%

7. I would choose to privatize adoption subsidies: Surveys from 72 respondents were excluded from the analysis. Responses from 133 respondents (65%) were included. As depicted in Chart 7, the vast majority of respondents (83%) *agreed* or *strongly agreed* that they would choose to privatize adoption subsidies. Again, there was general consensus among stakeholder groups, with 87% of DCYF workers, 85% of providers, and 76% of external stakeholders agreeing that they would choose adoption subsidies for privatization.

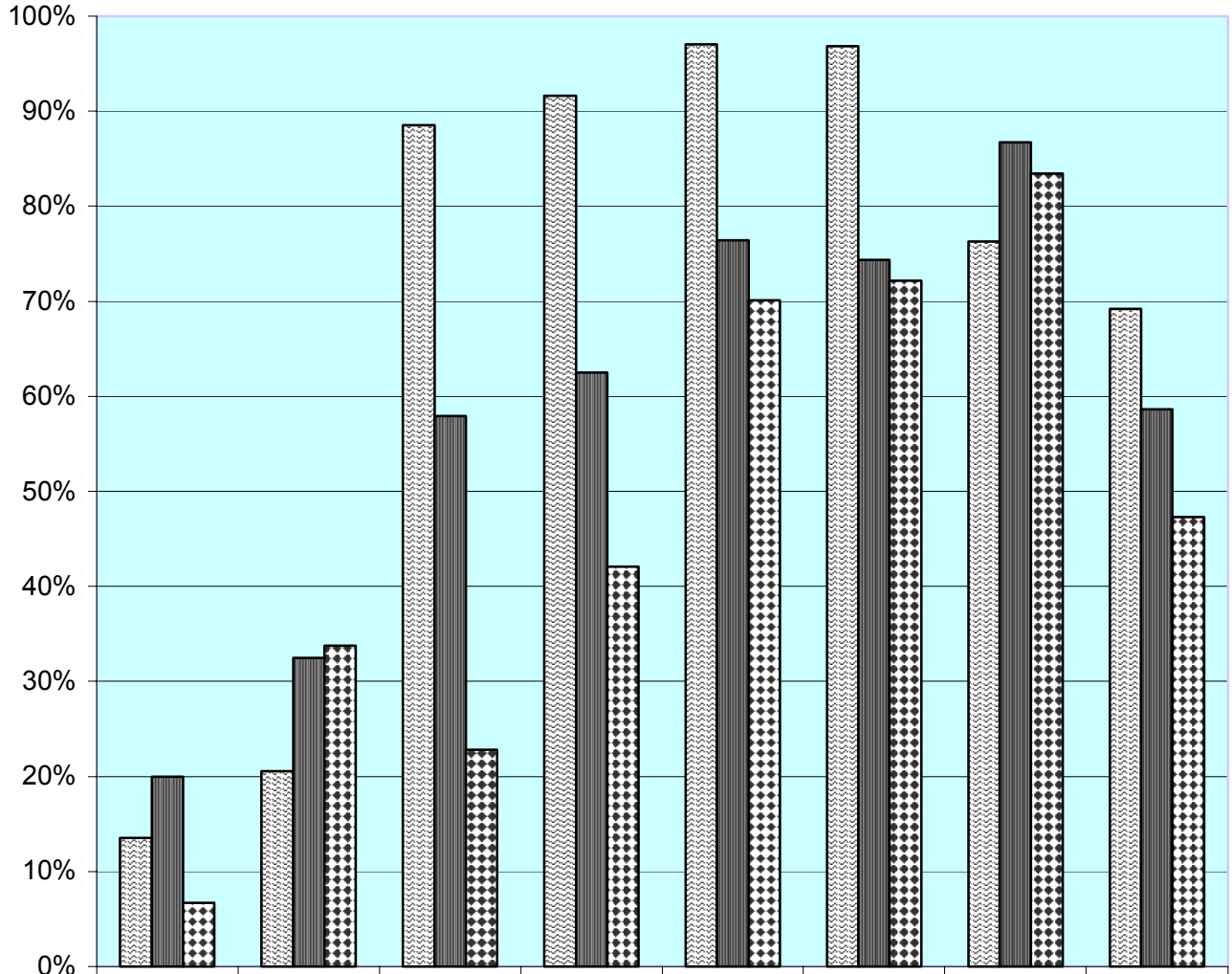
Chart 7: Privatization of the Adoption Subsidy



	All	Providers	Ext. Stake.	DES
DISAGREE	17%	15%	24%	13%
AGREE	83%	85%	76%	87%

In summary, as depicted in Chart 8, the three stakeholder groups showed a high level of agreement in several areas. Stakeholders were united in opposition to the privatization of the Hotline function and CPS Investigations. With the exception of the Hotline, CPS Investigation and adoption subsidy functions, providers were far more likely than other respondents to *agree* or *strongly agree* to the privatization of all other listed areas. With the exception of the hotline function, DCYF staff respondents were the least likely to *agree* or *strongly agree* with any privatization options. However, when forced to choose, DCYF staff were most supportive of Independent Living services, adoption case management, and adoption subsidies being privatized.

Chart 8: Agreement by Respondent and Case Management Area



	Investigation	Hotline	Out-of-Home CM	In-Home CM	Ind. Liv.	Adopt. CM	Adopt. Sub	Avg.
Providers	14%	21%	89%	92%	97%	97%	76%	69%
Ext. Stake.	20%	33%	58%	63%	76%	74%	87%	59%
DES	7%	34%	23%	42%	70%	72%	83%	47%

How Would You Rate Current Performance in Case Management Areas? (Only DCYF and Stakeholders Surveys)

The surveys for DCYF staff and external stakeholders asked respondents to rate current DCYF case management performance relative to the Hotline, CPS Investigations, In- Home, Out-of-home Care, Independent Living, Adoption and Adoption Subsidies. As illustrated in Table 5, the external stakeholders (foster, adoptive, and birth parents, CASAs, FCRB, other state agencies/divisions, Judicial, Advocates, and Tribal Leaders) rated performance less favorably than DCYF staff. For example, over half of DCYF respondents rated the performance of the Hotline as *excellent* or *very good* as compared to less than one third of external stakeholders (28%).

Table 5: Current Case Management Performance

Area	Respondent	Excellent N (%)	Very Good N (%)	Fair N (%)	Not Very Good N (%)	Poor N (%)
Hotline N=138	DCYF	7 (7)	46 (47)	43 (44)	1 (1)	1 (1)
	Stakeholder	3 (8)	8 (20)	24 (60)	4 (10)	1 (2)
	Total	10 (7)	54 (39)	67 (49)	5 (4)	2 (1)
Investigations N=136	DCYF	3 (3)	48 (50)	37 (39)	6 (6)	2 (2)
	Stakeholder		18 (45)	13 (32)	6 (15)	3 (8)
	Total	3 (2)	66 (48)	50 (37)	12 (9)	5 (4)
In-Home N=124	DCYF	3 (3)	32 (36)	48 (55)	4 (5)	1 (1)
	Stakeholder		8 (22)	18 (49)	9 (24)	2 (5)
	Total	3 (2)	40 (32)	66 (53)	13 (11)	2 (2)
Out-of-Home N=130	DCYF	1 (1)	39 (42)	46 (49)	7 (8)	
	Stakeholder	1 (3)	6 (16)	18 (49)	10 (27)	2 (5)
	Total	2 (1.5)	45 (35)	64 (49)	17 (13)	2 (1.5)
Independent Living N=125	DCYF	7 (8)	25 (27)	48 (42)	11 (12)	1 (1)
	Stakeholder		3 (9)	13 (39)	16 (49)	1 (3)
	Total	7 (6)	28 (22%)	61 (49)	27 (22)	2 (1)
Adoption N=127	DCYF	7 (8)	39 (42)	40 (43)	6 (7)	
	Stakeholder	2 (6)	5 (14)	13 (37)	11 (31)	4 (11)
	Total	9 (7)	44 (35)	53 (42)	17 (13)	4 (3)
Adoption Subsidy N=119	DCYF	5 (6)	25 (30)	45 (54)	7 (8)	1 (1)
	Stakeholder	1 (3)	6 (17)	16 (44)	9 (25)	4 (11)
	Total	6 (5)	31 (26)	61 (51)	16 (14)	5 (4)

How Would You Rate DES On Procurement and Monitoring? (Only DCYF staff and Providers)

The survey asked DCYF staff and provider respondents to rate DES performance on procurement, contract monitoring, and provider relations. As noted in the introductory summary of trends identified through research, these issues are among the areas that have proven problematic for public agencies and their private partners.

As depicted in Table 6, providers rated procurement and monitoring performance higher than DCYF staff in two areas. Twenty-six percent (26%) of providers rated performance in procurement and contract negotiation as excellent or very good as compared to 15% of DCYF staff. Nearly half of providers (48%) rated DES as excellent or very good in relation to establishing a level of mutual trust and respect as compared to 24% of DCYF staff.

The majority of both types of respondents, however, gave DES fair or not good ratings in all areas. The lowest ratings by both providers and DCYF respondents were given to quality monitoring and compliance. Fifty-nine percent of DCYF staff and 35% of providers rated DES performance in this area as not good or poor. If provider and DCYF ratings are accurate reflections of current performance, these finding indicate that improvements are needed in all areas if DCYF is going to effectively manage current and future privatized contracts.

Table 6: Ratings on Procurement, Monitoring, and Provider Relations

Area	Respondent	Excellent N (%)	Very Good N (%)	Fair N (%)	Not Good N (%)	Poor N (%)
Procurement & contract negotiation. N=98	DCYF	0	11 (15)	31 (41)	26 (35)	7 (9)
	Provider	1 (4)	5 (22)	12 (52)	5 (22)	
Quality & compliance monitoring. N=103	DCYF	2 (3)	10 (12)	21 (26)	28 (35)	19 (24)
	Provider	1 (4)	2 (9)	12 (52)	6 (26)	2 (9)
Establishing trust & respect. N=105	DCYF	3 (4)	16 (20)	38 (46)	23 (28)	2 (2)
	Provider	1 (4)	10 (44)	6 (26)	6 (26)	

The survey asked providers to rate DES in other contract management areas. As Table 7 shows, providers gave the highest rating to timely reimbursement. The lowest ratings were given for rewarding providers for good performance and holding providers accountable for poor results—both critically important under performance based contracting options.

Table 7: Ratings on Key Contract Management Areas

Area	Excellent N (%)	Very Good N (%)	Fair N (%)	Not Good N (%)	Poor N (%)
Ability to make timely reimbursement	1 (4)	7 (32)	11 (50)	2 (10)	1 (4)
The level of reimbursement	0	0	9 (41)	10 (45)	3 (14)
The flow of information & communication	0	3 (13)	17 (74)	3 (13)	
The training provided	0	0	11 (50)	9 (41)	2 (9)
The level of collaboration	0	6 (26)	11 (48)	6 (26)	
Rewarding providers for good results	0	0	3 (13)	17 (71)	4 (16)
Holding providers accountable for poor performance	0	1 (5)	6 (27)	11 (50)	4 (18)

The survey asked providers, "What is one thing DES could do to improve current procurement, negotiation or monitoring performance?" The providers offered many suggestions, as illustrated in the textbox.

The majority of comments focused on the need for greater flexibility in procurement, improved communications, onsite monitoring, improved negotiations based on true costs, problem-solving mechanisms, accountability for poor performance, and rewards for good results. Several providers also indicated the need for greater local control in procurement.

Improving Procurement & Monitoring

- There is no "negotiation." Let the market drive this!
- There is no monitoring and no resources for it. Devote some resources.
- Better communication before a huge issue arises.
- Monitoring should include visiting the agency.
- Provide more time, more answers & fewer amendments on RFPs. STREAMLINE!
- Don't renew contracts of agencies providing poor service just because they already had a contract.
- Pay rates that allow an agency to do better than just survive.
- There are no consequences for bad performance and no rewards for good results.

Can Private Agencies Provide Higher Quality Case Management At A Lower Cost?

The survey asked all respondents whether their level of agreement or disagreement with the statement: "In general, private agencies can provide higher quality case management services than the current system." Ninety-six percent of all respondents answered this question (N=198). Of this group, one-third (34%) *disagreed* or *strongly disagreed* with the statement, and just under one-third (30%) *agreed* or *strongly agreed.*

There were significant (striking) differences among stakeholders. Close to three-quarters (71%) of providers *agreed* or *strongly agreed* and only 2% *disagreed* or *strongly disagreed*; slightly more than one-third (36%) of external stakeholders *agreed* or *strongly agreed* and one-quarter

(24%) *disagreed* or *strongly disagreed*; and only 10% of DCYF staff *agreed* or *strongly agreed* with one-half (50%) *disagreeing* or *strongly disagreeing*.

The survey asked whether respondents agreed or disagreed with the statement: "Privatized case management will cost less than the current system." Ninety-two percent of respondents answered this question (N=188). Of this group, close to one- third (30%) *disagreed* or *strongly disagreed* with the statement and about one-fifth (22%) *agreed* or *strongly agreed*. Nearly half indicated they did not know. Providers were more likely to *agree* or *strongly agree*: 41% of providers *agreed* or *strongly agreed*. By contrast, one quarter (24%) of external stakeholders *agreed* or *strongly agreed* and one-third (32%) *disagreed* or *strongly disagreed*. Only 15% of DCYF staff *agreed* or *strongly agreed* that privatized case management will cost less and more than one-third (36%) *disagreed* or strongly disagreed.

*Were You Aware of the Legislative Language? (*DCYF staff and Providers)

The survey asked DCYF staff and providers to indicate the degree to which they agreed or disagreed with the statement: "I was aware of the legislative requirement to examine privatization options before this meeting." The findings revealed significant differences in the two groups. Only 40% of the DCYF staff that responded to the question (N=95) indicated they *agreed* or *strongly agreed* with the statement. By contrast, 84% of the providers that responded to the question (N=26) *agreed* or *strongly agreed* that they were aware of the privatization language in the legislative bill.

This disparity in awareness was also evident in the focus group discussions where it appeared that providers were familiar with national privatization trends, had considered options for privatization, and were well aware of legislative actions whereas DCYF workers did not seem as well informed.

Is the Work That You Do Valued By DES and the Legislature? (DCYF staff and Providers)

The DCYF survey asked respondents to indicate their level of agreement with the statement: "DES values the work that I do." The provider survey asked for responses to a similar statement: "DES values the services that my agency provides."

Forty-one percent (41%) of the DCYF staff (N=96) *agreed* or *strongly agreed* that DES values their work. By contrast, 80% of providers (N=25) *agreed* or *strongly agreed* that DES values the services that they provide.

The DCYF staff survey asked respondents to indicate their level of agreement with the statement: "The Legislature values the work that I do." The provider survey asked for responses to a similar statement: "The Legislature values the services that my agency provides."

Only 15% of the DCYF staff that responded (N=95) *agreed* or *strongly agreed* that the legislature values their work. By contrast, 60% of providers that responded (N=25) *agreed* or *strongly agreed* that the Legislature values the services provided by their agencies.

How Ready Is Your Agency For Privatization? (For Providers Only)

The survey instrument for providers asked respondents to rate their level of knowledge, experience and capacity in key areas related to readiness for privatization and the quality of the agency's relationship with DES. Not all providers responded to all questions.

The vast majority of providers (84%) rated their relationship with DES as either *excellent* or *very good.* One third (32%) said that the relationship was *excellent*, and more than one-half (52%) said that it was *very good.*

Providers also were asked about specific readiness areas in relation to privatization, as listed in Table 8. When the responses were analyzed by the size of the agency's contract with DES, some interesting findings emerged. Agencies with DES contracts under $5 million were significantly more likely to rate their understanding or experience as *excellent* or *very good* when compared with agencies with contracts over $10 million. Agencies with contracts with DES over $10 million were more likely to rate current knowledge and experience as *fair*. For example:

- 70% of the agencies with smaller contracts felt they had an *excellent* or *very good* understanding of privatized case management models, compared to 50% of the agencies with larger contracts.

- 72% of the agencies with smaller contracts believed they had an *excellent* or *very good* understanding of the roles of DES staff throughout the life of a case, compared to 25% of agencies with larger contracts.

- 77% of agencies with smaller contracts rated their understanding of risk and liability issues as *excellent* or *very good*, compared to 50% of the agencies with larger contracts.

- 77% of agencies with smaller contracts rated their capacity to track and report outcomes and fiscal data as *excellent* or *very good*, compared to 25% of the agencies with larger contracts.

The only area in which agencies with larger contracts gave higher self-ratings than agencies with smaller contracts was the current relationship with DES. All of the agencies with contracts over $10 million described the relationship as *excellent* or *very good*, compared to 76% of the agencies with smaller contracts.

There may be a number of explanations for these findings. Providers with contracts under $5 million may be overestimating their capacity in many of the readiness areas because they have less familiarity with how DES operates and less understanding of system challenges. Agencies with larger contracts seem to have a greater understanding of what they do not know and a more realistic judgment of their current capacity. Table 8 presents the results of the self-assessments of provider readiness.

Table 8: Provider Self-Ratings of Readiness

Area	Excellent	Very Good	Fair	Not Very Good	Poor
Knowledge of privatized case management models (N=24)	6 (2 5 %)	11 (46 %)	7 (29 %)		
Knowledge of risk-or-results-based payment options (N=25)	9 (36%)	9 (36%)	5 (20%)	2 (8%)	
Knowledge of the roles of DES workers (N=26)	10 (39%)	4 (15%)	11 (42%)	1 (4%)	
Knowledge of risk and liability (N=25)	12 (48%)	6 (24%)	6 (24%)	1 (4%)	
Experience providing case management (N=25)	11 (44%)	13 (52%)	1 (4%)		
Experience handling court-related processes for DES children (N=26)	6 (23%)	5 (19%)	11 (42%)	3 (12%)	1 (4%)
Your relationship with DES (N=25)	8 (32%)	13 (52%)	3 (12%)	1 (4%)	
Your capacity to track and report outcomes, and fiscal data. (N=25)	9 (36%)	6 (24%)	10 (40%)		

The survey included a list of areas that have proven difficult for private agencies in other privatization initiatives. Providers were asked to rank the top three areas in which their agency needs help to prepare for privatization. Very few respondents followed the directions and ranked areas but twenty-five respondents did check up to three areas. As Table 9 shows, court related procedures and the recruitment and retention of case managers and supervisors were the two areas that received the greatest response. QA/QI and best practices in case management were the two areas that received the fewest responses.

Table 9: Areas in Which Providers Need Help (N=25)*

Area	N	Percent of providers
Court related process	18	42.9%
Recruitment, training, retention of case managers/supervisors	11	26.2%
IT & Data tracking, reporting systems	8	19%
Financial & Risk Management	7	16.7%
Integration of CM w/ utilization management	7	16.7%
QA/QI with a focus on contract compliance and results	6	14.3%
Intro of best practices in CM	2	4.8%
Other	0	0%

*Total does not equal 100% as respondents could rank up to three concerns.

What Is The Impact of Privatization on Current Relationships With DES?

The survey asked external stakeholders how they thought privatization might affect their current relationship with DES. Twenty-nine stakeholders (52%) responded to the question and provided one or more comments about the impact of privatization on their current relationship with DES.

As illustrated by the sample of comments in the textbox, responses were mixed. Nine respondents (31%) anticipated little or no change in their relationship with DES; 4 respondents (14%) mentioned potentially negative consequences; and 4 respondents saw potential for an improved relationship with DES. The remainder of respondents highlighted both potential benefits and potential problems in relating to DES with the privatization of services.

Perceived Impact on External Stakeholders

- JPO and DES in my County have worked very hard to establish collaborative relationships. The relationships won't be crippled no matter what changes come. The decision must be based on the needs of children and families.
- Currently work with members from DCYF who run policy as well as programs; Healthy Families, PSSFP, other prevention. Would be worried about loss of institutional/historical knowledge and continuity of this work.
- Depends on that agency and staff as well as DES. Could become very cohesive or alternatively become fragmented.
- It presents a nightmare to a foster parent in dealing with private agency and DES.
- I see a loss of Intergovernmental relationships.
- Makes it even more difficult to work effectively with DES.
- Could only improve dramatically.

The DCYF survey asked staff to indicate the degree to which they *agreed* or *disagreed* with the statement: "Implementation of privatization would make me concerned about my job security." Respondents were also asked about possible employment opportunities within the private sector. As indicated in Table 10, the majority (58%) of the 96 respondents who answered the question about potential job loss were concerned that privatization would pose a threat to jobs. There were subtle differences when the respondent's experience and current position were considered but these differences were not statistically significant.

Table 10: Perceived Impact of Privatization on DCYF Staff (N=96)

Indicate how you feel about each statement.	Strongly agree N (%)	Agree N (%)	Not Sure N (%)	Disagree N (%)	Strongly Disagree N (%)
Implementation of privatization would make me concerned about my job.	27 (28)	29 (30)	22 (23)	12 (13)	6 (6)
Implementation of privatization would be viewed by me as an employment opportunity	5 (5)	12 (13)	39 (40)	17 (18)	23 (24)
I would never want to work for a private agency.	9 (10)	6 (6)	48 (50)	23 (24)	10 (10)

While not necessarily viewing privatization as an opportunity, the vast majority of DCYF staff appeared open to considering employment with a private agency.

Twenty-six of the respondents provided comments to add to or clarify their ratings on these issues. The examples in the textbox are typical of the comments about employment with private agencies—both pro and con. It was noteworthy that many DCYF staff said that they were nearing retirement in the State system and could not afford to leave unless they could retain their benefits.

Views on Working for A Private Agency

- Been there, done that. Felt insecure at the private agency.
- I feel that there would be less room for growth in a private agency & that benefits would not be as good. (I'm also close to retirement)
- I've experienced overwhelming inadequacy in private agencies.
- Not so much red tape with a private agency.
- If it was the right opportunity and I could help families, I would be interested.

What Is the Most Important Thing for DES to Consider When Making Decisions About Privatization?

The survey asked all respondents to list the top three things that DES should consider in weighing privatization issues. The written comments are consistent with issues raised by participants in the focus groups (described in the next section) and with comments provided in other responses to survey questions. Twenty-nine of the 42 providers (69%) offered 58 suggestions for DES' consideration. Thirty-four of the 56 external stakeholders (61%) offered 69 suggestions for consideration. Seventy-two of the 107 DCYF respondents (67%) offered 90 suggestions for consideration. There was consistency in the suggestions across respondent groups. Table 11 highlights frequently cited suggestions organized under seven broad topic areas and by the type of respondent.

Table 11: Most Important Things DES Should Consider in Making Privatization Decisions

Providers	Other Stakeholders	DCYF
Goals/Purpose		
Clearly define goals, objectives, roles and responsibilities as a first step. Who will decide why, when, and how to privatize –– Central or local DES?	Is the key issue $ savings or doing a better job? What are our flaws and how can privatization cure them? To the public, will it look like DES is trying to shift responsibility & "blame" to private sector?	The primary focus has to be on families and children - not employees. Why privatization? Should be clear and concise answer. What benefit are you looking for? What do you want to achieve?

Providers	Other Stakeholders	DCYF
Populations/Services		
Consider unique needs of metro Phoenix versus rural areas. If there is not adequate service capacity will providers have authority to increase it? Keep investigations w/ State, and services with providers -- we will be able to work more closely and collaboratively with families.	Consider the effect on foster parents when things are always changing How does it affect Tribes in regards to CPS and other services? How will you ensure cultural and religious sensitivity in services? Will this build on family-centered practices?	Where is the safety net? What if it doesn't work and the system has been dismantled? Prioritize areas for privatization that can be measured for achievement of safety & permanency outcomes. For profit organizations, number one concern is the profit! What about the kids and what they need?
Funding/Costs		
Will overdone (or badly done) oversight and hidden costs defeat any efficiency we achieve? Will the rates support the expectations? Will there be flexibility?	Won't administrative costs be higher? Money may not be saved.	Is this about money or quality? No qualified social worker would work at a private agency for the $ they could offer. Put enough money in to hire and keep qualified workers.
Procurement/Monitoring/Quality/Accountability		
Clearly define standards of care and quality and results expectations. Look at private agency capacity, experience, and past performance in selection. DES has significant deficiencies in the contracting/procurement areas that need to be remedied. Use this transition to improve the level of protections and the quality of care for children.	DES needs better contracts. Will this really improve services? How will DES know? Overseeing cases would be important and difficult. Allow for customer feedback to evaluate the quality of services CPS implements new ways of making services better and more efficient. But, there is no follow-up.	Many functions are currently done by private agencies. There appears to be little to no oversight. If we do privatize, need to ensure we choose qualified agencies. We need fair competition in bidding (not low ball bids). How will we accurately track performance? How will state deal with non-conformance to contracts?
Legal/ Ethical/Court		
Will we understand and be able to meet legal mandates? Providers will need training and support in legal/liability readiness. Is there buy-in from court systems?	Relationship that DES has with juvenile court & the effect privatization would have on the court system	I am not sure if privatized agencies can take positions in court as strongly as state employees. How would liability be handled? There is a conflict of interest--decision-making & money making.

Providers	Other Stakeholders	DCYF
DES & Provider Issues		
This should not be an outside entity "managing" the funding & contracting for services. Agencies chosen should have adequate resources to expand quickly. DES manages change poorly and this would be massive change! How does this fit with the new contracts they just signed for family preservation services?	DES does not have an infrastructure for oversight. There is a lack of accountability already with contract providers. Phase-In/Pilot the approach to work out kinks Will this benefit/improve ICWA notification to the Tribes? Would RBHA services improve/accept Tribal referrals to services? Will the Tribe have to compete for Title IV-E/B funds and would they lose out based on rural location of Tribes population?	How will private agencies monitor success/failure/neglect/malpractice? Will this be nonprofit versus for profit agencies? Religious based agencies may have bias in attitude/approach to CPS work in general. DES is a large & cumbersome agency where decisions are usually politically driven. How will you solve the staffing problem that currently exists?
Miscellaneous Words Of Wisdom		
GO SLOW Pilot first. With increased responsibility there should also be increased authority! Don't view this as a way to save money. You get what you pay for! Patience -- this won't be overnight results!	Keep dialogue open while planning Streamline communication after implementation. Rural areas see the focus as always being on the "state of Maricopa." Recognize that all districts have their own needs and polices & they are often very different from each other. Engage the faith community. Stay focused on the now, not past wrongdoing. Be more respectful to each other.	Just Say NO! Fix the issues don't just rename the agency. Understand privatized CPS isn't a "magic bullet." Legislators need to understand the problem before throwing the solution at us. Is leadership, at all levels, committed to privatization? Too much change too fast will overburden/stress the system. Do the opposite of the [name deleted] RBHA contract!

Findings from Focus Groups & Interviews

The Focus Groups

In September 2005, at the start of the project, the DES staff and the consultants identified the various types of stakeholders who would be invited to participate in focus groups. Decisions were made to hold focus groups with DCYF staff, providers, and external (non-provider) stakeholders. It was also decided that focus groups would be held in four of Arizona's six Districts. DES project staff identified local contacts in each of the four Districts. In advance of each of the focus group meetings, they emailed information about the project, the agenda for

focus groups, and the survey instrument that focus group participants would be asked to complete.

To ensure a broad-based mix of DCYF staff, local District Program Managers issued focus group notices and encouraged staff participation in meetings. To reach the provider community, it was determined that the Arizona Council of Human Service Providers would convene agencies from across the state at a meeting in Phoenix. With regard to the external (non-provider) stakeholders, Central Office DES staff initially identified individuals from the other stakeholder groups and then scheduled and arranged meeting logistics with CASAs, FCRBs, the Arizona Intertribal Council, the Arizona Foster and Adoptive Parent Association, the interagency Community Network Steering Committee in Tucson, and the Durango Court Dually Adjudicated Work Group.

Most focus groups lasted between 1.5 and 2 hours. Given the size of the provider group (over 40 participants), the focus group was extended to a three- hour time period. Following introductions, participants were told the purpose of the focus group and the ground rules for the discussion. Assurances were given that confidentiality would be maintained regarding all observations made in the surveys or revealed in discussions.

The same general format was used for all focus groups. First, instructions were provided for completing the surveys. Participants completed the surveys and then were asked if they had any questions about privatization or about the issues in the survey that they would like to raise for discussion. Typically, groups asked facilitators for information about privatization in other parts of the United States. When this occurred, brief information was provided on successes and challenges (as described in Part 1 of this report). For the remainder of the time, the discussion was free-flowing with participants encouraged to voice concerns or raise issues that they wanted to have addressed in any future privatization planning.

The discussions in all the focus groups revealed attitudes and perceptions about privatization that are consistent with information provided in the written surveys. DCYF staff were outspoken in their opposition to privatization. They used the focus group as an opportunity to share anecdotal negative experiences (particularly in relation to the RBHAs) to demonstrate that privatization of DCYF case management would not work. In contrast, the providers, while cautious, were much more enthusiastic about potential opportunities. The providers reported having considered various privatized case management options. They saw the opportunity for improved results in the creation of an integrated case management approach that would target children and youth with complex or therapeutic needs. They believed that they could create an effective partnership with the RBHAs to test a system of care model that would offer individualized wraparound services and more timely access to therapeutic and non- therapeutic care and supports to children and their families.

Alternately, providers also indicated that they would consider a random assignment pilot of all types of cases in which they would receive a set number (or percent) of randomly assigned referrals each month in a designated region and would have responsibility for case management until permanency was achieved. They stated that under either the integrated system of care or mixed caseload model, results could be compared between the publicly and privately managed cases to assess whether there was any advantage in terms of outcomes, quality, efficiency, and child and family satisfaction with services.

Although most providers appeared excited by the prospect of privatized case management, many also expressed concern about the potential challenges that their agencies would face in preparing for the change. As a group, they were united in their opinion that DES should proceed with caution and allow providers time (and resources) to support preparation. The level of awareness of potential barriers and difficulties was more apparent in the focus group discussions with providers than in the providers' written responses to the survey.

In the dialogue with external stakeholders, both positive and negative opinions were expressed about whether privatization could be an additional strategy that might help DES reach its goals. As a group, external stakeholders were more open to the idea of privatization than DCYF staff, but they were less optimistic than providers that privatization would make a significant difference. In general, they were quite supportive of current DES improvement efforts and the vision of DES leadership. On other issues, however, there was less unanimity. Many external stakeholders pointed to "entrenched" problems in moving a bureaucracy to accept change, and many questioned whether current reform efforts or privatization would be successful.

Within some external stakeholder groups, there was praise for the hardworking DCYF staff, and in other groups, participants stated that they held DCYF staff in low regard. Some groups expressed positive experiences with private agency staff while others questioned their motives and competencies. There was dissatisfaction expressed with current contracts with RBHAs, a widespread belief that the needs of children and families are not being met, and more than a little concern was expressed that a privatized child welfare case management system might have the same deficiencies.

Interviews

Central Office project staff arranged for individual interviews with the DES Director, DES administrative staff and Legislative staff and a meeting with the Children's Action Alliance. All interviews were helpful in providing a context for consideration of privatization and in gaining insights into current areas of strength and weakness. For example, DES administrative staff members stated that DCYF's greatest weakness in moving forward with a case management privatization initiative was the lack of current contract monitoring capacity. The interview with the DES Director, held mid-way through the focus groups, provided an opportunity to explore his thoughts about opportunities and challenges. He made clear that his key concern was that privatization efforts complement current DES goals and strategies.

3. Summary of Readiness Review Themes & Findings

In the first section of this report, a number of challenges to and key elements for successful implementation of privatization were described. Using those characteristics as a yardstick to measure readiness, the profile that emerged from the review is one of a system with significant strengths and equally significant challenges.

Areas of Strength

There are strengths in the current system's business practices indicating readiness to plan and implement a future privatization initiative. Strengths include:

- Clear Goals: DES is committed to reform and DCYF is in the midst of major improvement efforts, with clearly defined objectives and strategies for meeting goals. Privatized case management could be incorporated into one or more of the current initiatives.

- Positive Relationships: DES has extensive experience collaborating with private agencies and community leaders to find solutions to complex problems.

- Previous Experience: While procurement is not without problems, privatization is also not a new concept for Arizona. DES is familiar with how contracts can be structured and financing aligned to achieve improved results.

- Technology: CHILDS, the IT system, though imperfect, has been improved and is able to support many contract and payment functions.

- A Focus on Results: DES is able to generate a variety of performance reports that are being used currently to support planning and quality improvement efforts. For example, the recently launched data Dashboard is tracking key indicators related to the Blueprint. This capacity would be essential as one component of a monitoring system that would ensure the quality of any privatized case management system.

Areas That Require Attention

It was clear from the interviews, surveys and focus groups that a consensus about the privatization of case management does not currently exist. Among DCFY staff, providers and external stakeholders, views are divergent regarding privatization itself as well as the specific case management functions that lend themselves most effectively to privatization. Both DCYF and the providers will need to continue the dialogue to reach any true consensus on potential privatization efforts, a dialogue that will need to include other external stakeholders as well.

Given current assessments regarding the state of readiness on the part of both DCFY and the providers if case management were privatized, both DCYF and the private agencies would need to invest significant time and money to prepare for the change. The Framework in Part 3 of this report is intended to help guide continuing discussions. The following are among the barriers that DCYF must remedy before implementing privatized case management:

- Procurement, Negotiation & Monitoring for Compliance: Every group, including providers, voiced concerns about the manner in which contracts are negotiated and about the absence of effective contract monitoring on the part of DCYF. The inability to hold providers accountable for contract compliance and the failure to develop and ensure corrective actions even when problems have been clearly identified are areas that DCYF will need to address either within Contracts & Procurement or as part of an overall approach to QA/QI. In addition, DCYF must reassess its overall approach to procurement to ensure that providers

who have met or exceeded performance expectations are rewarded in evaluation criteria used in future procurements.

Although these challenges were identified by all stakeholders (contracted providers, external stakeholders, and by DCYF staff) who participated in focus groups, it is important to note that over the last year DCYF has implemented several procurement improvement processes that include the following: (1) DCYF now conducts statewide Requests for Information (RFI) meetings to obtain potential provider comments and ideas about a proposed Scope of Work for a service prior to the official release of the Request for Proposals; and, (2) new or renewed requests for contracted services include performance-based contracting components. To the extent possible with existing resources, DCYF does monitor contracts and attempts to hold providers accountable for contract compliance. However, DCYF acknowledges that this is an area that could be improved with additional staff capacity. Within the past several months in response to issues raised by the Protecting Arizona's Family Coalition (PAFCO) whose membership includes the Arizona Council of Human Service Providers, DES began a process to improve internal procurement and contract monitoring. The DES Office of Procurement and the Director's Office met with PAFCO and a number of providers, including DCYF providers, to discuss issues and provide education about the procurement process. This meeting resulted in implementation of a plan of Procurement Reform and Education, including further education of providers and DES staff. Planned DES Procurement improvements include the semi-centralization of the procurement solicitation process. By moving the solicitation responsibilities out of the program areas and into the centralized procurement office, some of the needed resources may be freed up to refocus the programmatic efforts on contract administration.

- Access To A Full Array of Quality Services and Placement Options, Including Behavioral Health Services: In the wake of the Jason K. Settlement Agreement, DES has worked diligently with the REBHAs to improve therapeutic services for children in the child welfare system. In spite of these ongoing efforts many stakeholders attributed DCYF's performance difficulties in the areas of safety, well-being, and permanency goal attainment to the caseworkers' inability to access needed therapeutic services or appropriate placements that the RBHAs manage. In addition, most DCYF staff described planning processes that were disjointed, duplicative, time-consuming, achieving few meaningful results, and, at times, operating at cross-purposes with DCYF mandates. As one caseworker put it, "I am always attending one meeting or another—often with the same people at the table, but the discussion is not focused on the case plan goals or what needs to happen to get the child home. It is like child welfare has become a stepchild of mental health."

  As noted in the previous section, the provider group, while acknowledging challenges, also saw an opportunity for an integrated system of care privatization project (pilot). They proposed bringing the RBHAs and providers together in a coordinated case management system that would result in a single case plan (the child's legal plan) that addresses not only safety, permanency, and well-being but also the child's education, health and behavioral health needs. Privatization of child welfare case management cannot fix inadequate service capacity. It will be difficult for private case managers to achieve improved results if the current access and capacity barriers are not addressed as part of the privatization plan. What is required is a willingness on the part of the RBHAs to go outside the parameters of their current contracts in support of a privatized DCYF case management initiative.

- The Current Work Environment: Caseworkers and other stakeholders noted the plethora of new initiatives that have been launched as part of the Governor's reform plan. Although most seemed supportive of the intent, many DCYF respondents also cited the difficulty in implementing so many reforms in such a short period of time. In addition, staffing shortages and high caseloads have contributed to low morale and increased caseworker stress. One caseworker's comments summed up sentiments heard at each DCYF focus group: "I know we are trying to improve but too many new programs are being started. We don't wait to see what's working before starting something new. It is taking a toll on workers."
- Improved Communication: By far, the greatest resistance to privatized case management is internal to DCYF, a reality that will be exacerbated by ineffective communication. If the discussion about privatization continues, it will be critical to engage staff in planning and to develop and implement an internal communications plan to ensure that staff is informed as decisions are made. Providers and external stakeholders also raised communication issues, noting the many DES improvements that are underway but also the lack of ongoing communication to the field. As one stakeholder put it, "DES is doing a lot of innovative things but nobody seems to be connecting the dots or if they are, we don't know about it." When an issue is as politically charged as privatization, managing communication will become increasingly important.
- Ensuring Provider Readiness: DCYF will have a willing partner in the private sector if a decision is made to proceed with one or more case management privatization pilots. Because the private agencies will be partners in any case management privatization initiative, it is essential that providers be ready to assume new responsibilities. The assessment revealed some wide differences in private agencies' self-assessments of their readiness for privatization of child welfare case management. Of importance to any privatization effort will be the development of readiness criteria, systematic evaluations of providers' readiness, and the provision of adequate time and technical assistance, as needed, to ensure that providers have the infrastructure, personnel and competencies to proceed before cases are assigned. Given current DCYF staff capacity this type of support and technical assistance would be difficult if not impossible for DCYF to provide.

Limitations of the Assessment

The assessment was conducted in response to the Legislative requirement to review options for the privatization of some or all portions of case management currently provided by DCYF. In order to be most responsive to the request a determination was made to assess interest and capacity in each of the areas currently managed by DCYF. Stakeholders were therefore asked to consider privatization in the context of how the current case management system is organized (i.e., by the type of service the child is receiving). DCYF respondents were familiar with how things are currently done and were able to respond easily to the questions. However, some providers and external stakeholders recognized that the organization of the survey did not allow for alternative approaches to be proposed. As one stakeholder noted, "If privatization were to occur shouldn't it be done to test a new approach that can possibly result in a more coordinated system rather than replicating current practice?" In hindsight the observation made by that stakeholder (as well as similar sentiments voiced by others) is correct. A clear finding from research studies is that simply changing from a public worker to a private one and holding all else constant will not result in improved outcomes for children and families. Should DCYF decide to continue the dialogue about the possible merits of privatization it will be important to pursue all options.

PART 3: RECOMMENDATIONS & A FRAMEWORK FOR DECISION MAKERS

This section includes recommendations for next steps and provides a framework that is intended to be a technical assistance resource for Arizona policymakers, administrators, and stakeholders to use in weighing any future child welfare case management privatization options.

Recommendations for Next Steps

This assessment occurred as a result of a legislative request and not as an outgrowth of DES' current reform efforts. The dialogue that occurred with stakeholders was beneficial not only in gauging perceptions about privatization but also identifying many areas of strengths and areas needing improvement in the current system.

As evident throughout this report there are hurdles to overcome and no clear consensus on the best course of action. However, there is also strong support from the provider community and from some external stakeholders to plan and implement a pilot project that is designed to complement current reform efforts and test innovative practices in order to enhance current performance. Based upon the level of interest and the overall assessment, the following recommendations are made:

- Make this report widely available to internal and external stakeholders for comment, including those who participated in focus groups and completed surveys.
- Regardless of whether or not the State moves to privatize any case management duties, it is strongly recommended that a DCYF Public/Private Partnership Work Group be formed to build upon the previously described Procurement Reform and Education effort. The focus of the newly created Work Group would not only be to address the barriers identified in this report but also to improve current business practices. It is recommended that if a Work Group is created it be comprised of internal and external stakeholders, including providers, and that the work be organized through the creation of subgroups charged with responsibility for examining and crafting approaches to address the identified issues outlined in the report and in the following framework. Both DCYF and any potential future privatized case management system can benefit from such an effort.
- It is recommended that DES expand its current internal procurement and monitoring improvement efforts to specifically address DCYF challenges. Given the amount of funds that currently support DCFY contracts and the number of children and families already served by private agencies, it is imperative that resources be allocated and plans implemented to address identified quality assurance and monitoring weaknesses. It would be ill advised to expand contracting efforts to include case management until capacity is adequate to monitor and enforce compliance of current and future contracts. Resources may be needed to support needed improvements, which may necessitate Legislative support.
- It is recommended that DES explore any potential legal, financial and risk impacts of privatizing any portion of case management services. Other states have privatized child welfare services, including case management, and have not encountered difficulties regarding their claims for reimbursement for foster care expenses under the federal Title IV-E program. Nonetheless, given the lack of explicit guidance from the U.S. Department

of Health and Human Services regarding the impact of privatization on states' claims for reimbursement under Title IV-E, it would be prudent to seek clarification of federal policy in this area. There is also a lack of clarity in state law and court rules that may preclude the private agencies from presenting the "State's" recommendations to the courts as agents of the state. If DES is required to have a state employee present to represent the department in all court appearances, this would result in considerable duplication of effort and expense. It is not clear if the Office of the Assistant Attorney Generals' attorneys would be able to represent the private agency case manager in these court proceedings as this Office does for CPS staff.

A Framework for Decision Makers

If privatization is to move forward and if the intent of any future privatization of case management is improved results and cost efficiency, significant energy will need to be devoted to planning the effort and to overcoming the previously described challenges. This framework is provided as a technical assistance resource for decision makers and the recommended Public/Private Partnership Work Group to use in improving current practices and weighing privatization options. The following principles provide guidance and raise issues in ten areas that would need to be addressed:

1. View Privatization As A Method to Improve Current Case Management

In far too many States, fiscal and contract reforms are treated as discrete, isolated efforts and not as an integral part of the State's overall approach to system improvement. Often, inadequate staff resources are committed to the planning phase. Planning for best practice takes time and the process needs to acknowledge - and expect - that DCYF staff and providers will need time to plan and prepare for any potential privatization of case management.

As Arizona examines options for privatization, it will be important to ensure that improvement efforts described in the previous section are the foundation for future privatization efforts. Any privatization plans that emerge should be supportive of and consistent with other State reform goals, strategies and initiatives.

DCYF will need to identify key Central Office staff to guide the effort and develop the infrastructure to support an inclusive planning process that engages external stakeholders throughout the planning and implementation, including District Office staff, providers, and other external stakeholders. Mechanisms will need to be created to link discussions with the ongoing work to implement the strategies set forth in the *Blueprint For Realigning Arizona's Child Welfare Program*.

Is the consideration of privatization taking place in the context of other State improvement efforts?

Is there an infrastructure to support planning?

How will Stakeholders be involved?

What resources will be required for planning?

How will planning decisions be communicated internally and to the field?

How long should the planning take before there is a "plan?"?

2. Define Success

Stakeholders will want to know whether the privatization effort worked to improve performance. That should be a straightforward question with a clear-cut answer. In many initiatives across the country, it isn't. For example, in a comparison of contracts with four of the Florida community based care agencies: one contract had 47 outcome measures, two contracts had seven, and one contract had nine. No contract directly stated what the overall measure of success would be. From the outset of planning, it would be important for DCYF, provider agencies, and external stakeholders to agree on the overall purpose and what constitutes success; define common performance requirements and child and family outcomes that will be used as indicators of success; and report performance on the same indicators over time. Unless this occurs the State will never be able to say conclusively whether privatization of case management was a success.

What does Arizona hope to achieve through privatization of case management?

What are the overarching goals and how will success be defined and measured?

How will results be communicated?

In weighing options for privatization and establishing broad goals, planners would need to rely upon current performance data and information gathered through the focus groups, surveys, and interviews to identify potential avenues where privatization could enhance strengths or remedy deficits. In setting performance targets and desired outcomes, it is important to start with a realistic assessment of current performance. DES has the capacity to generate performance reports on core permanency, safety, and well-being outcomes. The data in these reports will be critical as planners establish a baseline on which to build.

3. Have a Clear Rationale for Selecting the Target Population and the Case Management Model

There are seven areas where DCYF currently provides case management services for children and their families. Each of these broad areas was assessed for possible privatization benefits. As noted previously, no State has chosen to privatize the Hotline or CPS initial investigation functions, and it seems unlikely from the responses to the survey and focus group discussions that these areas would be viable options for privatization in Arizona.

Based upon national trends over the past decade, the more likely opportunities lie in the areas of out-of-home care, in- home services, independent living, adoption, and adoption subsidies. Although some of

Which children and families should be included?

- o Children in foster care or only those in therapeutic levels of care?
- o Children under age 6 in group care?
- o Dually adjudicated youth?
- o Youth in transition?
- o Children served in-home?
- o Children at risk of entering care?
- o Children with adoption as a permanency goal?
- o Children in the care of relatives?
- o A portion of some or all children in the current caseload or only new referrals?

Will the initiative be statewide or limited to a geographic region?

Will it be phased in over time, or all at once?

Is a pilot the right way to go?

these areas were attractive to some survey respondents, few were overwhelmingly endorsed by all. Furthermore, the choice of target population and the focus of privatization must be based not only on stakeholders' views but also on a host of other factors. While adoption and adoption subsidies or independent living appeared to have the greatest level of stakeholder support, offering the path of least resistance, those areas, if privatized, might not result in the greatest benefit for the children and families.

Arizona planners should weigh privatization in relation to current initiatives, asking: Is there a role for privatized case management that would add value to the initiative and to the broader system improvement effort? It was beyond the scope of this project to fully evaluate DES performance in case management areas to identify places where a new approach could perhaps produce better results. That assessment should be done before final decisions are made.

There are many privatized case management options that merit consideration. The integrated system of care option raised by providers is worthy of consideration because it not only would strengthen case management for a difficult to serve population but would also provide an opportunity to test a new approach to the integration of child welfare with behavioral health case management. There is no one "right" choice. Importantly, however, the decisions that are made about the target population for privatized case management should drive decisions about the services beyond case management that need to be included in the initiative.

Once the target population and focus are clear, the State will still need to decide the size of the population to be served and the geographic area(s) for the initiative. The initiative could be Statewide, with some level of flexibility for regional differences, and could be implemented through a gradual statewide phase-in or through a single pilot in one or more regions of the State. Stakeholders urged a cautious implementation approach, suggesting one (or more) pilots in several regions to demonstrate effectiveness over time with services provided to children and families residing in both urban and rural areas.

Who will develop and revise the case plan?

Who will handle court-related petitions and hearings?

At what point will the referral be made to the private agency?

Will it be a "no reject, no eject" system?

Who makes decisions about placement, level of care, permanency goals, and case closure?

At what point will the provider's responsibility for the case end -- at the time of permanency or for some period of time thereafter?

If the child returns to care, will the same agency pick up the case?

In cases of disagreement, who has ultimate authority?

What problem-solving mechanisms and dispute resolution processes will be needed?

4. Define Roles

Role clarity has been a prevailing concern for both public agencies and their contract providers in privatization efforts across the country. Some States have chosen a "dual" case management model in which public agency staff retain responsibility for certain functions while delegating responsibility for other decisions to the private agency.

Other initiatives provide contract oversight but delegate total control over key decisions to private agencies. Some initiatives start with

one model and evolve over time into something different. Some States define the case management approach, including specific caseload standards. Others have allowed private agencies the flexibility to define their approach, with the understanding that State and federal requirements and a limited number of performance standards will be met.

5. Ensure Service Capacity

When broad goals, target population(s), and roles are defined, it will be important to specify which services and supports will be available to the private case management agency, including the responsibility or authority they will have for fillings gaps in service availability prior to assuming case management duties.

One of the reported benefits of the lead agency model has been the expansion of both traditional and non- traditional services. If service expansion is to occur, flexible funds will be required and adequate time will be needed by the private agency to create a provider network or merge new services into the RBHA network.

Some initiatives have included limited funds and time as *start-up* to allow either the public agency or private contractor to expand services prior to the start of the privatized case management system. When funding and time for *start-up* are not built into the implementation, initiatives have encountered serious fiscal and programmatic challenges.

Given the proposed geographic scope and target population, what is the current service capacity?

What authority/funds will be provided to allow the private agency to stimulate the development of services?

What impact would a privatized case management system have on access to services to meet the child's mental health, health, dental, and education needs?

How would privatized case management affect existing DES service contracts?

Service capacity was of particular concern to the rural stakeholders who questioned how a privatized case management approach could work in the absence of an array of services that children and families need.

As noted in the assessment, many stakeholders were also concerned that the funding/services that are controlled and managed by the RBHA's would need to be integrated with any child welfare case management privatization effort. DCYF will need to work with stakeholders and build into any privatization plan a recognition of and plans for meeting gaps in service capacity and eliminating access barriers.

6. Design and Implement a QA/QI and Contract Monitoring System

As noted in Part 1 of this report, numerous research studies have revealed an inconsistent, inadequate or inappropriate approach to monitoring across privatization initiatives.

In this assessment, all stakeholder types identified the need for an improved monitoring system. There was strong agreement that private providers are not currently held accountable for the results that they are expected to achieve nor are they rewarded for good performance.

When initiatives across the country have worked to establish an effective monitoring system, disagreement commonly has arisen around the definition of results and the means of ensuring the validity of data that indicate whether results were or were not achieved.

How will DCYF monitor contracts to support innovation while safeguarding children?

What enhancements in monitoring and QA/QI will be needed to effectively monitor these types of contracts?

How much will it cost to make needed improvements?

Will national standards be used to shape the approach to the monitoring process?

In the early days of CBC implementation in Florida, for example, CBC agencies voiced concern in some sites that frequent reporting of data was required on too many and not always meaningful indicators. The lead agencies were subject to periodic (and at times, too frequent) onsite quality assurance reviews by state or local Department staff. Some CBC contracts required quarterly quality assurance reviews by the local Department office, four internal quality assurance reports, at least one administrative review, a minimum of six licensing reviews, an annual evaluation, an independent audit, preparation for national accreditation, daily entry of data, monthly reports including reconciliation of all expenditures.[26]

Over time, many Florida sites and other privatization initiatives have found a balance that allows the public purchaser to monitor for results while also granting the provider the flexibility to innovate. Many performance-based contract initiatives now combine monthly or quarterly Desk Reviews that are focused on results rather than process with a limited number of onsite visits that look in-depth at a random sample of cases, following a methodology similar to the federal review process for States (data analysis, record reviews, and interviews). Finally, an increasing number of initiatives are requiring national accreditation for providers as added insurance that the provider has the capacity to ensure a consistent quality of care. Meeting nationally accepted standards is one of the most effective means of ensuring overall quality of a system.

Planners need to carefully think through the monitoring process, drawing on the "lessons learned" from other communities that have struggled with finding the right balance and developing standards and quality assurance processes that promote contract compliance and the private agencies' achievement of defined results without stifling the provider's ability to innovate.

7. Assess Data Technology Needs

Most researchers have noted that privatized initiatives have placed a premium on access to real time information to guide case-level decisions and system planning. However, there is abundant evidence that many initiatives have lacked the technology or staff resources to collect or manage data.

Both public agencies and providers need data for operational decisions and successful contract management. The MIS must be able to track performance from a variety of different perspectives—client status, service utilization, service/episode costs linked with case plan goals, treatment, and outcomes. The system must be need-driven, flexible, user-friendly, and capable of generating useful reports for all users.

Additionally, at the case level, when private agencies assume case management responsibilities they are often allowed or required to enter data directly into the State's SACWIS. When private agencies have this requirement, they have often had to develop complex and dual entry mechanisms—running their own management information systems to manage their business processes and separately entering data into State systems to meet contract requirements—hardly an ideal or cost-effective solution.

What are the implications for DES data systems and the collection and use of data?

Will private agency case managers enter data directly into CHILDS, the State's information system? If not, how will DCYF ensure compliance with all federal and state data reporting requirements and maintain a single case record?

What MIS enhancements are required to obtain the real- time information needed to manage and evaluate the system?

What will technology enhancements cost?

What capacity must providers have?

How will DCYF verify integrity of data entered by providers?

How will data be used to monitor contracts?

How will data be used to guide future planning?

The necessity for dual data systems arises in part because few State systems are equipped for utilization management, provider network management, or claims/billing/ reconciliation/and payments—all core functions required in some private agency contracts.

During the focus groups, many of the providers and external stakeholders identified data technology as an area that might be problematic for implementation of a privatized case management system in Arizona. Planners of any privatized case management contract will need to assess the current IT capacity of DES and identify enhancements that may be required. They will need to ensure that contract agencies have the technological and human resource capacity to meet specified data collection and reporting requirements.

8. Identify Funding Sources and Financing Options

According to the most recent CWLA 50-state survey of child welfare financing trends, half of the states are now testing new methods of financing child welfare contracts. In the best-case scenario, these new reforms have increased flexibility and more closely aligned fiscal incentives with programmatic goals, resulting in better outcomes for children and families. Best-case scenarios, however, do not happen automatically.

Most child welfare privatization efforts are supported primarily by child welfare funds, but States are increasingly using funds outside of child welfare to better address the complex needs of the children and families served. Planners will need to identify funding sources and establish linkages with other child serving systems (such as mental health, substance abuse and Medicaid) for the provision of services that will not be reimbursed directly to the provider.

As the previous section indicated, one challenge that was frequently mentioned by focus group participants and described in survey responses was the manner in which current funding for therapeutic services is managed by RBHAs. If the child welfare system does not have a set aside pool of Medicaid funds to pay for therapeutic placements and services, it is essential that mechanisms be in place to ensure that child and family needs are being met through the RBHA plan.

Most privatized initiatives introduce some elements of financial risk. DES has some experience in risk-based contracting, although many providers indicated that the current mechanisms have not always been effective in stimulating the results desired. Risk-based contracts require providers to have the infrastructure, knowledge, and skills to consistently assess and meet the needs of the children and families they serve while managing resources to achieve fiscal goals.

What are the budget assumptions—that privatization will save money? Redirect money? Serve more people for same money? Improve quality but cost more money?

What are the funding sources and amounts that can be included?

Based on the available funds, scope, expectations, and provider capacities, what are the pros and cons of the various risk-based or other contracting options that offer financial incentives?

How will control over key decisions be balanced with the level of risk assumed?

How will the financing arrangement provide flexibility regarding resources?

Will risk be phased-in or introduced from the outset?

What mechanisms can best protect against loss? Will contracts limit profits/savings?

How can the payment schedule be structured to enhance programmatic and fiscal goals?

Will the funding be sufficient to support national caseload standards?

What will the impact be on federal revenue and overall state budget?

What are the anticipated start-up costs?

Prior to determining whether risk-based options are desirable or which risk-based financing option Arizona might use, it is important for planners to assess current provider capacity and to

carefully explore the pros and cons of different models with that capacity and interest in mind. It is equally important to assess DCYF's comfort level in relinquishing control over some decisions in return for the introduction of financial risk. It is unrealistic to embrace a full or partial risk contract and assume that current roles and responsibilities will remain intact.

9. Consider Staffing and Training Issues

In the past several years, the nationwide staffing crisis for both public and private child welfare agencies has become a well-documented and difficult to remedy reality. For that reason alone, it is important to acknowledge that any move towards privatization of case management may negatively impact the ability of DES to recruit and retain workers.

The degree of anxiety and frustration expressed by DCYF staff in every focus group was striking and disturbing. As one staff member pointed out, "It is naive to assume that discussions about privatization will not negatively affect staff morale at a time when we are already overworked, underpaid, and under- valued."

It is essential for planners to recognize that the discussions about privatization, regardless of the outcome, are likely to increase anxiety of the public agency staff. It is imperative that staff be engaged in any planning effort and that the State have a communications plan in place to ensure that timely and accurate information is disseminated as decisions are made.

What impact might the change have on public and private agency staff recruitment and retention?

What is the plan for communicating internally and externally to minimize misinformation?

What are the training implications for both public and private agency staff?

Will DES be able to capture IV-E training funds to prepare private agency case managers?

Will private agency case managers be required to complete training required for DCYF caseworkers?

Will DCYF set the standards for case manager qualifications or will providers be at liberty to set their own standards?

Concerns about staffing issues were not confined to DES staff. Providers were concerned that they would not be able to attract and retain qualified case managers and supervisors and questioned whether DES staff would be interested in transitioning to the private sector.

As noted in the readiness review, issues related to salaries, benefits, pensions, staff qualifications, and training will need to be addressed by planners as they weigh various privatization options.

10. Chart A Course From Planning to Implementation

Finally, if a decision is made to launch a privatization initiative, DCYF will need to finalize design elements and determine the best course for translating the vision into a solid procurement and implementation plan.

Throughout the planning, DCYF will need to determine the best means of engaging local District Offices, providers, and community stakeholders in the planning, without jeopardizing the integrity of a competitive procurement.

It will be important for the Request for Proposal (RFP) to describe in detail the purpose of the contract; the expected outcomes and deliverables; performance standards; methods for payment, including provisions for any bonuses or penalties; the responsibilities of the contractor, DCYF, and any other partnering agencies; and the mechanisms that will be used to monitor contract compliance and attainment of goals.

DCYF will need to develop a clear plan for implementation, evaluation, and continual refinement as changes are proposed and made. The detailed transition plan would need to address the impact on current DES operations (including DCYF staff recruitment and retention), and the additional supports, if any, that might be needed in the short term to support implementation.

What are the pros and cons of performance-based single agency contracts versus lead agencies?

Are there other hybrid models that could be developed?

What are the capacities, limitations, and interests of current providers in different structural and fiscal models?

If DES issues an RFP, who will be allowed to bid -- nonprofit firms or proprietary agencies as well? Existing individual provider agencies or newly created corporations comprised of multiple partners?

Are there sufficient DES staff resources to prepare the RFP?

How will the solicitation and review process be managed?

How will proposals be evaluated and best value be determined?

What role will District Offices have in shaping the design and the RFP?

If national studies are an indication, it is likely that approaches to financial risk, performance standards, and outcomes may evolve over time with increased knowledge and experience. Under the best-case scenario, these changes will occur as part of a continuous quality review and improvement process.

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Endnotes

[1] This document is adapted primarily from McCullough, C. (2003). Financing & Contracting Practices in Child Welfare Initiatives & Medicaid Managed Care: Similarities and Differences. CWLA: Washington, DC. Funded by the Center for Health Care Strategies.

[2] Freundlich, M. & Gerstenzang, S. (2003). An Assessment of the Privatization of Child Welfare Services. CWLA Press: Washington, DC. Email books@cwla.org.

[3] There have been several major research projects in recent years that have focused on management, finance and privatization changes occurring in state child welfare agencies across the nation. Studies include those conducted by the U. S. Government Accounting Office, the Child Welfare League of America (CWLA), George Washington University's study of contracting practices, a decade of reports of the Health Care Reform Tracking Project (HCRTP), which is a collaborative effort of the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, D.C. and the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development, and the previously cited Children's Rights study. All reports of the HCRTP are available from the Research and Training Center for Children's Mental Health, University of South Florida (813) 974-6271. Special analyses related to the child welfare population are available from the National Technical Assistance Center for Children's Mental Health at Georgetown University (202) 687-5000, deaconm@georgetown.edu. Information in this section draws from each of these efforts.

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[8] CWLA has conducted periodic national surveys since 1996. The last published report was in 2003, based upon data from 2001. See McCullough, C. & Schmitt, B. (2003). Management, finance, and contracting survey final report. Washington, DC: CWLA Press. The GAO conducted targeted surveys and interviews. See also: U.S. Government Accounting Office. (1998a). Child welfare: Early experiences in implementing a managed care approach, HEHS-99-8. Washington, DC: Government Printing Office; and U.S. Government Accounting Office. (1998b). Privatization: Questions state and local decision makers used when considering privatization options, USGAO/GGD-98-97. Washington, DC: Government Printing Office.

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